MEDICARE PLATINO CONTRACT

APPENDIX C (1) (23)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 002, SEGMENT 0

Module: PBP
Requested By: d3ua
PLAN SYSTEM INFORMATION

Last entry Date: 06/06/2022 PBP Software Version: 2023.01

Plan Ready for Upload 06/06/2022 05:29:52 PM SA Timestamp: Western Standard Time

MA BPT Timestamp: 06/06/2022 09:36:41 PM SA

Western Standard Time

PD BPT Timestamp: 06/06/2022 09:36:57 PM SA

Western Standard Time

Last Upload File Creation 06/06/2022 09:52:24 PM SA Timestamp: Western Standard Time

Upload Status: 06/06/2022 #02466

PLAN STATUS

Section B19 Status

Section C Status

Section D Status

Section Mrx Status

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Completed Section B15 Status Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed



Completed

Completed

Completed

Completed

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing MCS Classicare

Name:

Organization Web Site: www.mcsclassicare.com
Plan Name: MCS Classicare Platino Ideal

(HMO D-SNP)

Organization Type: Local CCP

Plan Type: HMO

Enrollee Type:

Part A and Part B

Service Area(s):

Service Area(s):

40010 - Adjuntas, PR

40020 - Aguada, PR

Service Area(s):

40030 - Aguadilla, PR

Service Area(s):

40040 - Aguas Buenas, PR

Service Area(s): 40050 - Aibonito, PR
Service Area(s): 40060 - Anasco, PR
Service Area(s): 40070 - Arecibo, PR
Service Area(s): 40080 - Arroyo, PR

Service Area(s): 40090 - Barceloneta, PR
Service Area(s): 40100 - Barranquitas, PR
Service Area(s): 40110 - Bayamon, PR

Service Area(s): 40120 - Cabo Rojo, PR Service Area(s): 40130 - Caguas, PR Service Area(s): 40140 - Camuy, PR

Service Area(s): 40145 - Canovanas, PR
Service Area(s): 40150 - Carolina, PR
Service Area(s): 40160 - Catano, PR

Service Area(s): 40160 - Catano, PR
Service Area(s): 40170 - Cayey, PR
Service Area(s): 40180 - Ceiba, PR
Service Area(s): 40190 - Ciales, PR
Service Area(s): 40200 - Cidra, PR

Service Area(s): 40210 - Coamo, PR
Service Area(s): 40220 - Comerio, PR
Service Area(s): 40230 - Corozal, PR
Service Area(s): 40240 - Culebra, PR

Service Area(s):

Service Area(s):

40250 - Dorado, PR

Service Area(s):

40260 - Fajardo, PR

Service Area(s): 40265 - Florida, PR
Service Area(s): 40270 - Guanica, PR
Service Area(s): 40280 - Guayama, PR
Service Area(s): 40290 - Guayanilla, PR

Service Area(s): 40300 - Guaynabo, PR Service Area(s): 40310 - Gurabo, PR

Service Area(s):

Service Area(s): 40330 - Hormigueros, PR

40320 - Hatillo, PR

6/7/22, 3:54 PM	PBP
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5577

002 Plan ID: Segment ID: 0 2023 **Contract Period:**

Plan Geographic Name: Puerto Rico

Is this an Employer-Only No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-No approved Continuation Area?

Yes

Do you intend to participate in

the PLATINO program?

Is this a Special Needs Plan? Yes

Dual-Eligible Special Needs Plan Type:

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

No

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Yes

SECTION A: SECTION A-3

Participating Pharmacy

www.mcsclassicare.com

Website Address: Formulary Website Address:

www.mcsclassicare.com www.mcsclassicare.com

Physician Website Address: **Customer Service Contact**

(866)627-8183

Phone Number for Current Medicare Beneficiaries:

Customer Service Contact

(787)620-2530

Local Phone Number for

Current Medicare

Beneficiaries:

(866)627-8181

Customer Service Contact Phone Number for Prospective

Medicare Beneficiaries:

Customer Service Contact Local Phone Number for

Prospective Medicare

(787)620-2528

Beneficiaries:

Customer Service Contact Phone Number for Current (866)627-8183

Part D Medicare

Beneficiaries:

(787)620-2530

Customer Service Contact Local Phone Number for

Current Part D Medicare

Beneficiaries:



6/7/22, 3:54 PM	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
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	No

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

No

Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

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

Is there a service-specific

No

No

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 No

Coinsurance?

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

Is there an enrollee

No

No

Deductible?

Is there an enrollee

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required? Yes
Is a referral required for Yes

Inpatient Hospital-Acute

Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 1

Does the plan provide No

Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

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

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

Is there an enrollee No

Coinsurance?

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



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Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Hospital Psychiatric benefit

period?

Original Medicare

Is authorization required?

Yes

Is a referral required for

No

Inpatient Psychiatric Hospital

Services?

Notes:

Preauthorization required through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #2 SNF - BASE 1

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

No

Part C?

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

SNF admission?

Indicate the Number of

Zero

Hospital Days Required Prior

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

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

Is there an enrollee

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit

Original Medicare

period?

Is authorization required?

Yes

Is a referral required for SNF

Yes

Services?

SECTION B: #3 CARDIAC AND PULMONARY



REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac No 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 No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

No

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes
Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee No

Copayment?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

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

Does the plan provide Yes

Worldwide Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency



Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

Is there a Maximum Plan

No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

No

Copayment?

Is authorization required?

Yes

Is a referral required for

No

Partial Hospitalization?

Notes:

Preauthorization required through MCS Solutions,

except for Emergency and

Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific

No



Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee No

Deductible?

No Is there an enrollee

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Home Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Yes

Chiropractic Services as a supplemental benefit under

Part C?

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

Routine Care:

Is this benefit unlimited for No, indicate number

Routine Care?

Indicate number of visits for

Routine Care:

Select Routine Care Every year

periodicity:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee

Copayment?

No



Is there an enrollee

Deductible?

No

Is authorization required?

No

Is a referral required for Chiropractic Services?

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 2

Is authorization required?

Yes

Is a referral required for

No

Occupational Therapy

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required?

No

Is a referral required for

Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

Mental Health Specialty Services - Non-Physician?

Notes:

Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide

No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

No

Is a referral required for

Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

Is authorization required?

No

Is a referral required for Other

Yes

Health Care Professional

Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

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Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes Is a referral required for No

Psychiatric Services?

Notes: Preauthorization required

through MCS Solutions.

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes Is a referral required for No

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?

Yes

Select the Medicare-covered

benefits that may have

: 7a: Primary Care Physician

Services

Additional Telehealth Benefits

available:

: 7d: Physician Specialist

Services

: 7e1: Individual Sessions for

Mental Health Specialty

Services

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training

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

No

Telehealth?



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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required for

No

Additional Telehealth

Services?

Is a referral required for

No

Additional Telehealth

Services?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

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SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Yes

Outpatient Diagnostic

Procedures/Test/Lab Services?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Yes

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required for Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for No

Medicare-covered Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient

Hospital Services?

Is a referral required for No

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No

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?
Is a referral required for

Yes Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required?

No

Is a referral required for

No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

1

Does the plan provide

Yes

Outpatient Blood Services as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Three (3) Pint Deductible

Waived

Select type of benefit for Three (3) Pint Deductible

Mandatory

Waived:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?



Is there an enrollee

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

Deductible?

Is there an enrollee

No

No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for

Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide

Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit:

Plan Approved Health-related

Location

Select type of benefit for Plan

Approved Health-related

Mandatory

Location:

Is this benefit unlimited for number of trips for Plan

Approved Health-related

Location?

Indicate number of trips for

Plan Approved Health-related

Location:

Select Plan Approved Health-

related Location Trips

periodicity:

Select Type of Transportation

for Plan Approved Health-

related Location:

No

24

SHINISTRACION Contrato Número

Every year

One-way

POSDE

EMR

: Medical Transport

Select Mode of Transportation

for Plan Approved Health-

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

No

Is there an enrollee

Copayment?

Is authorization required? No Is a referral required for No

Transportation Services?

Notes: Transportation to Plan-

Approved Location provided by contracted transportation

provider.

No

No

SECTION B: #11A DME - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred Yes

vendors/manufacturers for Durable Medical Equipment

(DME)?

Is authorization required? Ye

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 1

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

No

Contrato Número

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Is there an enrollee

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 3

Is authorization required? Yes

Pre-authorization by PCP (for Notes:

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 2

Is there an enrollee No

Copayment?

Do you limit Diabetic Yes

Supplies and Services to those from specified manufacturers?

Is authorization required? Yes

Pre-authorization by PCP (for Notes:

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? No Is a referral required for No SHINISTRACION Contrato Número

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited for

No

Number of Treatments?

Indicate limit for Number of

6

Treatments:

Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific

No

Maximum Plan Benefit

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-

Yes

The-Counter (OTC) Items as a supplemental benefit under

Part C?

Select type of benefit for OTC

Mandatory

Items:

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount?

0.00

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Does your Maximum Plan

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

Yes



Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

Are you offering Nicotine

No

Replacement Therapy (NRT) as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Does this cover all of the OTC

No

list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: This benefit is combined with

the SSBCI Benefit Card. The combined amount appears in

Section D.

No

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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? No Is a referral required? No

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

Does the plan provide the

Annual Physical Exam as a

No



Yes

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

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

Massage*

Select type of benefit for

Health Education:

Mandatory

Select type of benefit for

Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for

Nutritional/Dietary Benefit?

Indicate number of visits for Nutritional/Dietary Benefit:

6

Indicate setting for

Individual Sessions

No, indicate number

Nutritional/Dietary Benefit: Select type of benefit for

Fitness Benefit:

Mandatory

Indicate type of Fitness

: Physical Fitness

Benefit offered (Select all that

apply):

Select type of benefit for

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

Hotline):

Mandatory

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

: Web/Phone-based technologies : Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

No, indicate number

Is this benefit unlimited for Alternative Therapies?

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Indicate number of visits 6

offered for Alternative

Therapies:

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

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited? No Indicate limit for number of 6

sessions

Indicate the number of Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 4

Is there a service-specific No

Maximum Plan Benefit Coverage amount for Other **Defined Supplemental**

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

Is there a service-specific No

Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

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

Defined Supplemental

Benefits?

Nutritional/Dietary Benefit Personal evaluation and diet Notes:

plan designed by licensed dietitian according to patient's

health needs, including exercise suggestions.

Fitness Benefit Notes:* Exercise and Nutrition

> Education Interventions. Member has access to fitness classes to promote physical

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Contrato Númer

activity and a healthier

lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement faceto-face visits with a boardcertified physician to treat the most common conditions, such as allergies, flu, among

others.

Remote Access Technologies (Nursing Hotline) Notes:

Nursing Hotline.

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

Alternative Therapies Notes:* Foot reflexology is limited to

six (6) visits per year and must be ordered by a physician or

medical professional.

Therapeutic Massage Notes: Therapeutic Massage must be

ordered by a physician or medical professional.

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

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

No

No

Deductible?

Is there an enrollee

Copayment?

Is authorization required? No Is a referral required for No

Kidney Disease Education

Services?

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

Is there a service-specific No

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

No

Coinsurance?

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Is there an enrollee No

Deductible?

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

Is there an enrollee No

Copayment?

Is authorization required for No

Medicare-covered Glaucoma

Screening?

Is authorization required for No

Medicare-covered Diabetes Self-Management Training?

Is authorization required for No

Medicare-covered Barium

Enemas?

Is authorization required for

Medicare-covered Digital

Rectal Exams?

Is authorization required for

Medicare-covered 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

No

No

No

Is there a Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

Is Authorization Required? Yes
Does the plan offer step Yes

therapy?

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D No

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 No

Preventive Dental Items as a

Contrato Número

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supplemental benefit under

Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Yes

Comprehensive Dental Items as a supplemental benefit

under Part C?

Select enhanced benefits:

: Non-routine Services

: Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

routine Services:

Mandatory

Is this benefit unlimited for

Yes

Non-routine Services?

Select type of benefit for

Mandatory

Diagnostic Services:

Is this benefit unlimited for

Diagnostic Services?

No, indicate number

Indicate number of visits for

Diagnostic Services:

1

Select the Diagnostic Services

periodicity:

Every six months

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

No, indicate number

Indicate number of visits for

Restorative Services:

Select the Restorative Services

Every three years

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Mandatory

Endodontics:

Is this benefit unlimited for

Yes

Endodontics?

Select type of benefit for

Mandatory

Periodontics:

Is this benefit unlimited for

Yes

Periodontics?

Select type of benefit for

Extractions:

Mandatory

Is this benefit unlimited for

Yes

Extractions?



PBP Data Report 6/7/22, 3:54 PM

Select type of benefit for

Mandatory

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Yes

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type: Indicate Maximum Plan period

Benefit Coverage amount:

3000.00

Select the Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

No Is there an enrollee

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes No

Is a referral required for Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye

Yes

Exams as a supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited for

No, indicate number

Routine Eye Exams?

Indicate number of exams for

1

Routine Eye Exams:

Select the Routine Eye Exams

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit

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Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Yes

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses: Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Mandatory

Is this benefit unlimited for

Contact lenses?

Yes

Yes

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited for

Eyeglasses (lenses and

frames)?

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SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eyeglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eyeglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type:

period

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700.00

Do you offer a Combined Max Yes

Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum

Plan Benefit Coverage

amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for No

Eyewear?

Notes: Eyewear benefit maximum

amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Exams as a supplemental benefit under Part C?

Select enhanced benefits: Routine Hearing Exams

: Fitting/Evaluation for

Hearing Aid

Yes

Select type of benefit for

Routine Hearing Exams:

benefit for Mandatory ing Exams:

Is this benefit unlimited for

No, indicate number

Routine Hearing Exams?

Indicate number for Routine 1

Hearing Exams:

Every year

Select Routine Hearing Exams

periodicity:

.

Select type of benefit for

Fitting/Evaluation for Hearing

Aid:

Mandatory



1

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

Aid?

Indicate number for

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

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

No

Is there an enrollee

No

Deductible?

Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit Yes

under Part C?

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for

Hearing Aids (all types):

Mandatory

Is this benefit unlimited for

No, indicate number

Hearing Aids (all types)?

2

Indicate quantity for Hearing

Aids (all types):

Every year

Select Hearing Aids (all types)

periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Benefit Coverage Amount

Both ears combined

apply per ear or for both ears combined?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type:

period

Indicate Maximum Plan

2500.00

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Contrato Número

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Benefit Coverage amount:

Indicate Maximum Plan

Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

No

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

No

Is a referral required for

Yes

Hearing Aids?

Notes:

Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices.

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

Does your plan include MA

No

Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special

Yes

Supplemental Benefits for the

Chronically III?

Select what type of benefit

: Additional Benefits

your SSBCI includes:

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

Does your VBID/MA

Yes

Uniformity Flexibility/SSBCI

benefit offer additional Part C

benefits?

How many packages do your

1

Additional Benefits contain?

(1-15)

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

Is this package applicable to

SSBCI

VBID or MA Uniformity Flexibility or SSBCI?

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

Contrato Número

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6/7/22, 3:54 PM

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 : Other 1 : Other 2 : Other 3 : Other 4 : Other 5

Crohn's disease or Ulcerative Other 1 Description:

colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive

pulmonary disease (COPD)

Severe mental retardation Other 4 Description: Other 5 Description: Moderate to Severe Autism

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

No

Is there a prerequisite for any additional benefits for this

package?

Select all the Non-Medicarecovered additional benefits

: 13i: Non-Primarily Health Related Benefits for the

offered in this package: Chronically Ill

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

Are any benefits exempt from No the plan-level deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE **AMOUNT): PACKAGE #1**

Is there a package level No maximum coverage amount?

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

The following SSBCI benefits Notes:

Contrato Número

will be offered:

- SSBCI Card* w/monthly periodicity and rollover

- Pest Control and General Supports for Living - Home Assistance Services w/quarterly periodicity

- Transportation for Non-Medical Needs

The following general categories will be covered for the SSBCI Card:

- 1. Food, produce and prepared foods
- 2. General supports for daily living
- 3. Transportation to Non-Medical needs
- 4. OTC, Hygiene, personal care, first aid, hurricane preparedness items
- 5. Gasoline and auto repairs
- 6. Cleaning Products, Air Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances
- 7. Social needs benefits
- 8. Services supporting self-direction
- 9. Copays and coinsurances for health services, supports for complementary therapies 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia
- 7. Diabetes
- 8. End-stage liver disease
- 9. End-stage renal disease (ESRD)
- 10. Severe hematologic disorders
- 11. HIV/AIDS





12. Chronic lung disorders 13. Chronic and disabling mental health conditions

14. Neurologic disorders

15. Stroke

16. Crohn's Disease

17. Ulcerative Colitis

18. Anemia

19. Chronic Obstructive Pulmonary Disease (COPD)

20. Moderate to Severe

Autism

21. Severe Mental Retardation

22. Rheumatologic disease

23. Hx of cancer (Personal

history of cancer)

24. Hypertension

25. Valvular heart disease

26. Cerebrovascular disease

27. Chronic viral hepatitis C

28. Chronic liver disease

29. Neurodegenerative disease

30. Malnutrition and Cachexia

31. Obesity

32. Chronic kidney disease

33. Colostomy status

34. Non-pressure chronic

ulcer

35. Others (as identified).

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit

: Food and Produce

your Non-Primarily Health

: Pest Control

Related Benefits for the

: Transportation for Non-

Chronically III includes: Medical Needs

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND

PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental

Yes

benefit under Part C?

Select type of benefit for Food

Mandatory

and Produce:

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan

0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Coverage periodicity:

Every month

Is there a service-specific

No

Contrato Número

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Food

No

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: This benefit is combined with

OTC. The combined amount appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC

Items.

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

Does the plan provide Pest

Yes

Control as a supplemental benefit under Part C?

Select type of benefit for Pest

Mandatory

Control:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Ν̈́ο

Is there an enrollee

Is there an enrollee

Deductible?

No

Copayment?

Is authorization required?

No

Is a referral required for Pest

No

Control?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

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Notes:

Services listed in this category will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General Supports

for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Yes

Does the plan provide

Transportation for Non-Medical Needs as a

supplemental benefit under

Part C?

Select enhanced benefit:

Plan-approved Location

Select type of benefit for Plan-

approved Location:

Mandatory

Every year

One-way

Is this benefit unlimited for number of trips for Plan-

approved Location?

Indicate number of trips for

Plan-approved Location:

0

No

Select Plan-approved Location

Trips periodicity:

Select Type of Transportation

for Non-Medical Needs for Plan-approved Location:

Select Mode of Transportation

for Non-Medical Need for

Plan-approved Location:

: Medical Transport : Other, Describe

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific

Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

Coinsurance?

Is there an enrollee

Deductible?

No

No

No

No



SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Transportation for Non-

Medical Needs?

Notes:

Fleet includes 4-door sedans,

minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the beneficiary qualifies for

SSBCI.

Yes

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

Does the plan provide General

Supports for Living as a supplemental benefit under

Part C?

Select type of benefit for

Mandatory

General Supports for Living:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:

Home Assistance - Twelve (12) visits per year (three per quarter) for Home Assistance



(Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance, Hairstyling, Basic Gardening) and categories listed under Pest Control.

SECTION C: V/T - GENERAL - US

Do you offer a US

No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan

No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-

NETWORK)

Is there an In-Network

Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum

Lower

Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?

Indicate In-Network

3400.00

Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply

to the In-Network Maximum

: In-Network Medicarecovered benefits

Enrollee Out-of-Pocket cost:

Does the In-Network

Yes

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING -

GENERAL

Do you offer Reductions in

No

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined

Yes

1

Supplemental Benefits with

uniform cost sharing?

Select the number of

Combined Supplemental Benefit packages you are

offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included : 13b: Over-the-Counter

(OTC) Items

in your Combined

: 19b: Additional Benefits for

VBID/UF/SSBCI

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6/7/22, 3:54 PM PBP Data Report

Supplemental Benefit

package:

What is your combined

supplemental benefits mode of

delivery?

: Other

Other Description: Co

Combined SSBCI Card/OTC

benefit

No

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined Yes

Supplemental Benefits with a shared maximum plan benefit

amount?

Max Plan Benefit Amount: 90.00

Select Maximum Plan Benefit

Coverage Amount Periodicity:

Do you offer Combined No

Supplemental Benefits with a

shared visit limit?

SECTION D: NOTES

d visit limit?

Notes: Non-SSBCI eligible members

Yes

will receive full card allowance in OTC.

Every month

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit: Defined Standard

Describe the components of standard Retail your pharmacy network (select all that apply): Standard Mail-Order

: Long-Term Care

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

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-thecounter medications (OTCs)

under the utilization management program?

amount(s) that apply:

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost

: Standard Retail Cost Sharing

sharing Location/supply - 1 month Supply

: Standard Retail Cost Sharing

- 2 month Supply

: Standard Retail Cost Sharing

- 3 month Supply

EMR

ROMINISTRACION

COMMINISTRACION

CO

30 Enter number of days for Standard Retail Cost Sharing

1-month supply:

Enter number of days for Standard Retail Cost Sharing

2-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 Outof-Network Pharmacy 1-

month supply:

Select all Standard Mail-Order Cost Sharing Location/supply

amount(s) that apply:

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

Select the Long-Term Care

Pharmacy one month Location/supply amount(s)

that apply:

Enter number of days for Long-Term Care Pharmacy 1-

month supply:

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

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

for the first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D No Benefits and/or Part D Rewards and Incentives under the VBID Model?

: Out-of-Network Pharmacy -

one month supply

60

90

30

90

: Standard Mail-Order - 3-

month supply

: Long-Term Care Pharmacy -

1-month supply

31

No

Yes

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6/7/22, 3:55 PM PBP Data Report

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 017, SEGMENT 0

Module: PBP
Requested By: d3ua
PLAN SYSTEM INFORMATION

Last entry Date: 06/06/2022 PBP Software Version: 2023.01

Plan Ready for Upload
Timestamp:

MA BPT Timestamp:

06/06/2022 05:31:09 PM SA
Western Standard Time
06/06/2022 09:36:42 PM SA

Western Standard Time

PD BPT Timestamp: 06/06/2022 09:36:57 PM SA

Western Standard Time

Last Upload File Creation 06/06/2022 09:52:24 PM SA Western Standard Time Upload Status: 06/06/2022 #02466

PLAN STATUS

Section D Status

Section Mrx Status

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed Section C Status Completed



Completed

Completed

PBP Data Report

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing MCS Classicare

Name:

Organization Web Site: www.mcsclassicare.com
Plan Name: MCS Classicare Platino
Progreso (HMO D-SNP)

Trogreso (TIMO

Organization Type: Local CCP
Plan Type: HMO

Enrollee Type: Part A and Part B 40010 - Adjuntas, PR Service Area(s): Service Area(s): 40020 - Aguada, PR 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 Service Area(s): 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR 40090 - Barceloneta, PR Service Area(s): Service Area(s): 40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR Service Area(s): 40120 - Cabo Rojo, PR 40130 - Caguas, PR Service Area(s):

Service Area(s): 40140 - Camuy, PR Service Area(s): 40145 - Canovanas, PR 40150 - Carolina, PR Service Area(s): Service Area(s): 40160 - Catano, PR Service Area(s): 40170 - Cayey, PR Service Area(s): 40180 - Ceiba, PR 40190 - Ciales, PR Service Area(s): Service Area(s): 40200 - Cidra, PR Service Area(s): 40210 - Coamo, PR Service Area(s): 40220 - Comerio, PR Service Area(s): 40230 - Corozal, PR Service Area(s): 40240 - Culebra, PR Service Area(s): 40250 - Dorado, PR Service Area(s): 40260 - Fajardo, PR

Service Area(s):

Service Area(s):

40250 - Dorado, PR

40260 - Fajardo, PR

Service Area(s):

40265 - Florida, PR

40270 - Guanica, PR

Service Area(s):

40280 - Guayama, PR

Service Area(s):

40290 - Guayanilla, PR

Service Area(s):

40300 - Guaynabo, PR

Service Area(s): 40310 - Gurabo, PR Service Area(s): 40320 - Hatillo, PR

Service Area(s): 40330 - Hormigueros, PR

PBP Data Report

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): Service Area(s): 40380 - Juncos, PR Service Area(s): 40390 - Lajas, PR Service Area(s): 40400 - Lares, PR 40410 - Las Marias, PR Service Area(s): 40420 - Las Piedras, PR Service Area(s): 40430 - Loiza, PR Service Area(s): Service Area(s): 40440 - Luquillo, PR Service Area(s): 40450 - Manati, PR Service Area(s): 40460 - Maricao, PR 40470 - Maunabo, PR Service Area(s): 40480 - Mayaguez, PR Service Area(s): 40490 - Moca, PR Service Area(s): 40500 - Morovis, PR Service Area(s): Service Area(s): 40510 - Naguabo, PR Service Area(s): 40520 - Naranjito, PR 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): 40580 - Rincon, PR Service Area(s): 40590 - Rio Grande, PR Service Area(s): 40610 - Sabana Grande, PR Service Area(s): Service Area(s): 40620 - Salinas, PR 40630 - San German, PR Service Area(s): 40640 - San Juan, PR Service Area(s): 40650 - San Lorenzo, PR Service Area(s): 40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): Service Area(s): 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR Service Area(s): 40740 - Vieques, PR Service Area(s): Service Area(s): 40750 - Villalba, PR 40760 - Yabucoa, PR Service Area(s): Service Area(s): 40770 - Yauco, PR Contract Number: H5577



6/7/22, 3:55 PM PBP Data Report

No

Yes

Plan ID: 017 Segment ID: 0

Contract Period: 2023

Plan Geographic Name: Puerto Rico

Is this an Employer-Only No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-approved Continuation Area?

Do you intend to participate in Yes

the PLATINO program?

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)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

SECTION A: SECTION A-3

Participating Pharmacy www.mcsclassicare.com

Website Address:
Formulary Website Address:

Physician Website Address:

www.mcsclassicare.com

www.mcsclassicare.com

Customer Service Contact (866)627-8183

Phone Number for Current Medicare Beneficiaries:

Customer Service Contact (787)620-2530 Local Phone Number for

Current Medicare
Beneficiaries:

Customer Service Contact (866)627-8181 Phone Number for Prospective

Medicare Beneficiaries:

Customer Service Contact (787)620-2528 Local Phone Number for

Prospective Medicare Beneficiaries:

Customer Service Contact (866)627-8183 Phone Number for Current

Part D Medicare
Beneficiaries:

Current Part D Medicare

Customer Service Contact (787)620-2530 Local Phone Number for

Beneficiaries:

PBP Data Report

6/7/22, 3:55 PM	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-4	(866)627-8181
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
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	No

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

No

Inpatient Hospital-Acute Services as a supplemental

benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required?

Yes

Is a referral required for

Yes

Inpatient Hospital-Acute

Services?

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

Does the plan provide

No

Inpatient Hospital Psychiatric Services as a supplemental

benefit under Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Does this plan's Medicare-

No

covered benefit cost sharing vary by hospital(s) in which

an enrollee obtains care?

No

Coinsurance?

Is there an enrollee

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



PBP Data Report

6/7/22, 3:55 PM

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Hospital Psychiatric benefit

period?

Is authorization required?

Yes

Is a referral required for

No

Inpatient Psychiatric Hospital

Services?

Notes:

Preauthorization required through MCS Solutions, except for Emergency and

Urgency Services.

Original Medicare

SECTION B: #2 SNF - BASE 1

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

Part C?

Do you allow less than 3 day

inpatient hospital stay prior to SNF admission?

Indicate the Number of

Zero

Yes

Hospital Days Required Prior

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

No

Maximum Enrollee Out-of-

Pocket Cost?

aximum Emonee Out-or-

SECTION B: #2 SNF - BASE 2

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

Is there an enrollee

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit

Original Medicare

file:///C:/Users/id4198/OneDrive - Medical Card System Inc/Desktop/Transferencia Documentos IMDB-01/2023 Medicare Advantage/2023 HPMS Re...

period?

Is authorization required?

Yes

Is a referral required for SNF

Yes

Services?

SECTION B: #3 CARDIAC AND PULMONARY



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REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac No 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 No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee No

Copayment?

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

No

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

No Is there an enrollee

Copayment?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT

COVERAGE - BASE 1

Does the plan provide Yes

Worldwide Emergency/Urgent Coverage as a supplemental

benefit under Part C?

: Worldwide Emergency Select enhanced benefit:



6/7/22, 3:55 PM PBP Data Report

Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

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

No

Coverage?

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes: Coverage is managed through

reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

No

Copayment?

Is authorization required? Yes
Is a referral required for No

Partial Hospitalization?

Notes: Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific No



Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home

Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide

Yes

Chiropractic Services as a supplemental benefit under

Part C?

Select enhanced benefit:

: Routine Care

Select type of benefit for

Mandatory

Routine Care:

Is this benefit unlimited for

No, indicate number

Routine Care?

Indicate number of visits for

6

Routine Care:

Select Routine Care

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

PBP Data Report 6/7/22, 3:55 PM

No

Is there an enrollee

Deductible?

Is authorization required? No Is a referral required for Yes

Chiropractic Services?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 2

Is authorization required? Yes Is a referral required for No

Occupational Therapy

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required? No Is a referral required for Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

PBP Data Report 6/7/22, 3:55 PM

No Is there an enrollee

Copayment?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 3

Yes Is authorization required? Is a referral required for No

Mental Health Specialty Services - Non-Physician?

Preauthorization required Notes:

through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

No Is there an enrollee

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? No Is a referral required for Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

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

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

No

Psychiatric Services?

Notes:

Preauthorization required through MCS Solutions.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

Yes

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:

: 7a: Primary Care Physician

Services

: 7d: Physician Specialist

Services

: 7e1: Individual Sessions for Mental Health Specialty

Services

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training

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

No

PBP Data Report 6/7/22, 3:55 PM

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 3

Is authorization required for No

Additional Telehealth

Services?

Is a referral required for No

Additional Telehealth

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required? No Is a referral required for No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 4

Is authorization required?

Yes

Is a referral required for

Yes

Outpatient Diagnostic

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

Yes

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required for

Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for

No

Medicare-covered Observation Services?

Is a referral required for

Is a referral required for Medicare-covered Outpatient Yes

No

Hospital Services?



Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

Yes

Is a referral required for

Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required?

No

Is a referral required for

No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

1

Does the plan provide

Yes

Outpatient Blood Services as a supplemental benefit under

Part C?

Select enhanced benefit:

: Three (3) Pint Deductible

Waived

Select type of benefit for

Three (3) Pint Deductible

Mandatory

Waived:

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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6/7/22, 3:55 PM PBP Data Report

Is there an enrollee

No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for

Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide

Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit:

Plan Approved Health-related

Location

Select type of benefit for Plan

Mandatory

Approved Health-related

Location:

Is this benefit unlimited for

No

number of trips for Plan

Approved Health-related

Location?

Indicate number of trips for Plan Approved Health-related 32

Location:

Select Plan Approved Health-

related Location Trips

Every year

periodicity:

Select Type of Transportation

for Plan Approved Healthrelated Location:

One-way



: Medical Transport

Select Mode of Transportation

for Plan Approved Health-

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required? Is a referral required for

No No

Transportation Services?

Transportation to Plan-Notes:

> Approved Location provided by contracted transportation

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred

Yes

vendors/manufacturers for **Durable Medical Equipment**

(DME)?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 1

Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 3

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 2

Is there an enrollee

No

Copayment?

Do you limit Diabetic

Yes

Supplies and Services to those from specified manufacturers?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

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Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited for

Indicate limit for Number of

No

Number of Treatments?

6

Treatments:

Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-

Yes

The-Counter (OTC) Items as a supplemental benefit under

Part C?

Select type of benefit for OTC

Mandatory

Items:

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan

Benefit Coverage amount: Select Maximum Plan Benefit

Every month

Coverage periodicity:

Does your Maximum Plan

Yes

0.00

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?

Are you offering Nicotine No Replacement Therapy (NRT)

as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Does this cover all of the OTC No list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: This benefit is combined with

the SSBCI Benefit Card. The combined amount appears in

Section D.

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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

No

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? No Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a

No



Yes

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

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

Massage*

Select type of benefit for

Health Education:

Mandatory

Select type of benefit for

Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

Indicate number of visits for

Nutritional/Dietary Benefit:

6

Indicate setting for

Nutritional/Dietary Benefit:

Individual Sessions

: Physical Fitness

No, indicate number

Select type of benefit for

Fitness Benefit:

Mandatory

Indicate type of Fitness

Benefit offered (Select all that

apply):

Select type of benefit for

Remote Access Technologies (including Web/Phone-based

Mandatory

technologies and Nursing Hotline): Select the type of Remote

Access Technologies offered (Select all that apply):

: Web/Phone-based technologies : Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for

No, indicate number

Alternative Therapies?

FMR

Indicate number of visits

offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 3

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited?

No

Indicate limit for number of

6

6

sessions

Indicate the number of

Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 4

Is there a service-specific

No

Maximum Plan Benefit Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee

No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

Is authorization required?

No

Is a referral required for Other

No

Defined Supplemental

Benefits?

Nutritional/Dietary Benefit

Notes:

Personal evaluation and diet

plan designed by licensed dietitian according to patient's

health needs, including exercise suggestions.

Fitness Benefit Notes:* Exercise and Nutrition

Education Interventions. Member has access to fitness classes to promote physical



6/7/22, 3:55 PM PBP Data Report

activity and a healthier lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement faceto-face visits with a boardcertified physician to treat the most common conditions,

such as allergies, flu, among

others.

Remote Access Technologies

Nursing Hotline.

(Nursing Hotline) Notes:

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

Alternative Therapies Notes:* Foot reflexology is limited to

six (6) visits per year and must be ordered by a physician or

medical professional.

Therapeutic Massage Notes: Therapeutic Massage must be

ordered by a physician or medical professional.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Is there an enrollee

Pocket Cost?

No

Coinsurance?

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

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for No

Kidney Disease Education

Services?

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

Is there a service-specific

No

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

No

Coinsurance?



Is there an enrollee

No

Deductible?

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

Is there an enrollee

No

Copayment?

Is authorization required for

No

Medicare-covered Glaucoma

Screening?

Is authorization required for

No

Medicare-covered Diabetes Self-Management Training?

Is authorization required for

No

Medicare-covered Barium

Enemas?

Is authorization required for

No

Medicare-covered Digital

Rectal Exams?

Is authorization required for No

Medicare-covered EKG following Welcome Visit?

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

Is a referral required for any

No

Services?

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

Is there a Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

Is Authorization Required?

Yes

Does the plan offer step

Yes

therapy?

Does the benefit step from

: Part B to Part B?

(select all that apply):

: Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D

No

home infusion drugs as part of

a bundled service as a

a bundled service as a mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

No

Preventive Dental Items as a



EMR Masses Yes

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: : Non-routine Services

> : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

routine Services:

Mandatory

Is this benefit unlimited for

Non-routine Services?

Yes

Select type of benefit for

Diagnostic Services:

Mandatory

Is this benefit unlimited for

Diagnostic Services?

No, indicate number

Indicate number of visits for

Diagnostic Services:

1

Select the Diagnostic Services

periodicity:

Every six months

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

No, indicate number

Indicate number of visits for

Restorative Services:

1

Select the Restorative Services

periodicity:

Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Mandatory

Mandatory

Endodontics:

Is this benefit unlimited for

Yes

Endodontics?

Select type of benefit for

Periodontics:

Is this benefit unlimited for

Yes

Periodontics?

Select type of benefit for

Mandatory

Extractions:

Is this benefit unlimited for

Yes

Extractions?



PBP Data Report 6/7/22, 3:55 PM

Yes

Yes

Mandatory

Select type of benefit for

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan Plan-specified amount per

period Benefit Coverage type: 4000.00 Indicate Maximum Plan

Benefit Coverage amount:

Select the Maximum Plan Every year

Benefit Coverage periodicity:

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee No

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes No Is a referral required for

Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Yes Does the plan provide Eye

Exams as a supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for Mandatory

Routine Eye Exams:

Is this benefit unlimited for No, indicate number

Routine Eye Exams?

Indicate number of exams for 1

Routine Eye Exams:

Select the Routine Eye Exams Every year

periodicity:

Is there a service-specific No

Maximum Plan Benefit

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Coverage amount?

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Copayment?

No Is there an enrollee

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Yes

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses : Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Mandatory

Is this benefit unlimited for

Contact lenses?

Yes

Select type of benefit for

Eyeglasses (lenses and frames):

Is this benefit unlimited for

Eyeglasses (lenses and

frames)?

Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eyeglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eyeglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount?

Select the Maximum Plan

Plan-specified amount per

period Benefit Coverage type:





6/7/22, 3:55 PM PBP Data Report

1000.00

Do you offer a Combined Max Yes

Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum

Plan Benefit Coverage

amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

Deductible?

Is there an enrollee

No

No

No

No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for No

Eyewear?

Notes: Eyewear benefit maximum

> amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Exams as a supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Routine Hearing Exams : Fitting/Evaluation for

Hearing Aid

Select type of benefit for

Routine Hearing Exams:

Mandatory

Is this benefit unlimited for Routine Hearing Exams?

No, indicate number

Indicate number for Routine

Hearing Exams:

1

Select Routine Hearing Exams

periodicity:

Every year

Select type of benefit for

Fitting/Evaluation for Hearing

Aid:

Mandatory



PBP Data Report 6/7/22, 3:55 PM

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

Aid?

Indicate number for

1

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there an enrollee

No

Deductible?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing

Yes

Aids as a supplemental benefit

under Part C?

Select enhanced benefits: Select type of benefit for

Mandatory

: Hearing Aids (all types)

No, indicate number

Hearing Aids (all types):

Is this benefit unlimited for

Hearing Aids (all types)?

Indicate quantity for Hearing

Aids (all types):

2

Select Hearing Aids (all types)

Every year

periodicity:

combined?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Benefit Coverage Amount

apply per ear or for both ears

Select the Maximum Plan

Plan-specified amount per

Both ears combined

Benefit Coverage type:

period

Indicate Maximum Plan

3000.00





Benefit Coverage amount:

Indicate Maximum Plan Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? No Is a referral required for Yes

Hearing Aids?

Benefit and Maximum Plan Notes:

> Coverage Amount includes benefit for repair of devices.

SECTION B: #19 VBID/MA UNIFORMITY

FLEXIBILITY/SSBCI

Does your plan include MA No

Uniformity Flexibility with

reductions in cost or additional benefits?

Do you offer Special Yes

Supplemental Benefits for the

Chronically Ill?

: Additional Benefits Select what type of benefit

your SSBCI includes:

SECTION B: #19B ADDITIONAL BENEFITS FOR

VBID/UF/SSBCI

Does your VBID/MA Yes

Uniformity Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your 1

Additional Benefits contain?

(1-15)

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

Is this package applicable to

SSBCI

VBID or MA Uniformity Flexibility or SSBCI?

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

PACKAGE #1

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PBP Data Report

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

6/7/22, 3:55 PM

: 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 : Other 1 : Other 2 : Other 3 : Other 4 : Other 5

Other 1 Description: Crohn's disease or Ulcerative

colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive

pulmonary disease (COPD)

Other 4 Description: Severe mental retardation Moderate to Severe Autism Other 5 Description:

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

No

Is there a prerequisite for any additional benefits for this

package?

Select all the Non-Medicare-: 13i: Non-Primarily Health covered additional benefits Related Benefits for the

Chronically III 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

No

the plan-level deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE **AMOUNT): PACKAGE #1**

Is there a package level No maximum coverage amount?

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

Notes: The following SSBCI benefits Contrato Número

will be offered:
- SSBCI Card* w/monthly periodicity and rollover
- Pest Control and General Supports for Living - Home Assistance Services w/quarterly periodicity
- Transportation for Non-Medical Needs

The following general categories will be covered for the SSBCI Card:

- 1. Food, produce and prepared foods
- 2. General supports for daily living
- 3. Transportation to Non-Medical needs
- 4. OTC, Hygiene, personal care, first aid, hurricane preparedness items
- 5. Gasoline and auto repairs
- 6. Cleaning Products, Air Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances
- 7. Social needs benefits
- 8. Services supporting self-direction
- 9. Copays and coinsurances for health services, supports for complementary therapies 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia
- 7. Diabetes
- 8. End-stage liver disease
- 9. End-stage renal disease (ESRD)
- 10. Severe hematologic disorders
- 11. HIV/AIDS



PBP Data Report 6/7/22, 3:55 PM

- 12. Chronic lung disorders
- 13. Chronic and disabling mental health conditions
- 14. Neurologic disorders
- 15. Stroke
- 16. Crohn's Disease
- 17. Ulcerative Colitis
- 18. Anemia
- 19. Chronic Obstructive Pulmonary Disease (COPD)
- 20. Moderate to Severe

Autism

- 21. Severe Mental Retardation
- 22. Rheumatologic disease
- 23. Hx of cancer (Personal

history of cancer)

- 24. Hypertension
- 25. Valvular heart disease
- 26. Cerebrovascular disease
- 27. Chronic viral hepatitis C
- 28. Chronic liver disease
- 29. Neurodegenerative disease
- 30. Malnutrition and Cachexia
- 31. Obesity
- 32. Chronic kidney disease
- 33. Colostomy status
- 34. Non-pressure chronic

ulcer

35. Others (as identified).

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health : Food and Produce : Pest Control

Related Benefits for the

Transportation for Non-

Chronically III includes: Medical Needs

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental

Yes

benefit under Part C?

Mandatory

Select type of benefit for Food

and Produce:

Yes

Is there a service-specific

Maximum Plan Benefit

Indicate Maximum Plan

Coverage amount?

0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Coverage periodicity:

Every month

Is there a service-specific

No





Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND

PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Food

No

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:

This benefit is combined with OTC. The combined amount appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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

Does the plan provide Pest

Yes

Control as a supplemental

benefit under Part C?

Mandatory

Control:

Is there a service-specific

Select type of benefit for Pest

No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

No

Is there an enrollee Copayment?

Is authorization required?

No

Is a referral required for Pest

No

Control?

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

BASE 3: PACKAGE #1

Contrato Número

PBP Data Report 6/7/22, 3:55 PM

Services listed in this category Notes:

will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection

- Any of the services listed under "Home Assistance" (filed under "General Supports

for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Yes

Does the plan provide

Transportation for Non-Medical Needs as a

supplemental benefit under

Part C?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-

approved Location:

Mandatory

Is this benefit unlimited for number of trips for Plan-

approved Location?

No

Indicate number of trips for

Plan-approved Location:

0

Select Plan-approved Location

Trips periodicity:

Every year

Select Type of Transportation

for Non-Medical Needs for

Plan-approved Location:

One-way

Select Mode of Transportation : Medical Transport for Non-Medical Need for : Other, Describe

Plan-approved Location:

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

No Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee

Coinsurance?

No

Is there an enrollee No

Deductible?



SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Transportation for Non-

Medical Needs?

Notes:

Fleet includes 4-door sedans,

minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the beneficiary qualifies for

SSBCI.

Yes

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

Does the plan provide General Supports for Living as a

supplemental benefit under

Part C?

Select type of benefit for

Mandatory

General Supports for Living:

Is there a service-specific

Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:

Home Assistance - Twelve (12) visits per year (three per quarter) for Home Assistance

Contrato Número

23 - 004

Contrato Número

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6/7/22, 3:55 PM PBP Data Report

(Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance, Hairstyling, Basic Gardening) and categories listed under

Pest Control.

No

Lower

SECTION C: V/T - GENERAL - US

Visitor/Travel Program?

Do you offer a US

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-

NETWORK)

Is there an In-Network Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum

Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?

Indicate In-Network 3400.00

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 Yes

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING -

GENERAL

Do you offer Reductions in

No

Yes

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with

supplemental Benefits wi uniform cost sharing?

Select the number of 1

Combined Supplemental Benefit packages you are offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included

: 13b: Over-the-Counter

: In-Network Medicare-

covered benefits

(OTC) Items

in your Combined : 19b: Additional Benefits for

VBID/UF/SSBCI

Supplemental Benefit

package:

What is your combined

supplemental benefits mode of

delivery?

Other Description:

: Other

Combined SSBCI Card/OTC

henefit

No

Yes

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined Supplemental Benefits with a

shared maximum plan benefit

amount?

Max Plan Benefit Amount:

80.00

Select Maximum Plan Benefit

Coverage Amount Periodicity:

Every month

Do you offer Combined

Supplemental Benefits with a

shared visit limit?

No

SECTION D: NOTES

Notes:

Non-SSBCI eligible members

will receive full card allowance in OTC.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug

(Part D) benefit?

Yes

Select the type of drug benefit: Describe the components of

your pharmacy network (select all that apply):

Defined Standard : Standard Retail

Out-of-Network : Standard Mail-Order Long-Term Care

Sponsor attests that it will comply with 42 CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-

counter medications (OTCs) under the utilization management program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

No

Select all Standard Retail Cost

: Standard Retail Cost Sharing - 1 month Supply

sharing Location/supply amount(s) that apply:

: Standard Retail Cost Sharing

- 2 month Supply

: Standard Retail Cost Sharing

- 3 month Supply



6/7/22, 3:55 PM PBP Data Report

Enter number of days for Standard Retail Cost Sharing

1-month supply:

Enter number of days for Standard Retail Cost Sharing

2-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 Outof-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 1month 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?

30

60

90

: Out-of-Network Pharmacy -

one month supply

30

: Standard Mail-Order - 3month supply

90

: Long-Term Care Pharmacy - 1-month supply

31

No

Yes

No

Contrato Número M OCAOS DE SAV

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 029, SEGMENT 0

Module:

PBP

Requested By:

d3ua

PLAN SYSTEM INFORMATION

Last entry Date:

06/06/2022

PBP Software Version:

2023.01

Plan Ready for Upload

06/06/2022 05:31:19 PM SA

Timestamp:

Western Standard Time

MA BPT Timestamp:

06/06/2022 09:36:42 PM SA

Western Standard Time

PD BPT Timestamp:

06/06/2022 09:36:57 PM SA

Western Standard Time

Last Upload File Creation

06/06/2022 09:52:24 PM SA

Timestamp:

Western Standard Time

Upload Status:

06/06/2022 #02466

PLAN STATUS

Section B18 Status

Section B19 Status

Section C Status

Section D Status

Section Mrx 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 Completed Section B11 Status Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed



Completed

Completed

Completed

Completed

Completed

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing MCS Classicare

Name:

Organization Web Site: www.mcsclassicare.com
Plan Name: MCS Classicare Platino
MasCa\$h (HMO D-SNP)

Local CCP

Organization Type: Local (
Plan Type: HMO

Enrollee Type:

Service Area(s):

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

Service Area(s):

40060 - Anasco, PR

Service Area(s):

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

Service Area(s):

40130 - Caguas, PR

40140 - Camuy, PR Service Area(s): Service Area(s): 40145 - Canovanas, PR 40150 - Carolina, PR Service Area(s): Service Area(s): 40160 - Catano, PR Service Area(s): 40170 - Cayey, PR Service Area(s): 40180 - Ceiba, PR Service Area(s): 40190 - Ciales, PR 40200 - Cidra, PR Service Area(s): Service Area(s): 40210 - Coamo, PR 40220 - Comerio, PR Service Area(s):

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

Service Area(s):

40280 - Guayama, PR

Service Area(s): 40290 - Guayanilla, PR Service Area(s): 40300 - Guaynabo, PR

Service Area(s): 40310 - Gurabo, PR Service Area(s): 40320 - Hatillo, PR

Service Area(s): 40330 - Hormigueros, PR



PBP Data Report

6/7/22, 3:54 PM

40340 - Humacao, PR Service Area(s): 40350 - Isabela, PR Service Area(s): 40360 - Jayuya, PR Service Area(s): 40370 - Juana Diaz, PR Service Area(s): 40380 - Juncos, PR Service Area(s): 40390 - Lajas, PR Service Area(s): Service Area(s): 40400 - Lares, PR Service Area(s): 40410 - Las Marias, PR Service Area(s): 40420 - Las Piedras, PR 40430 - Loiza, PR Service Area(s): Service Area(s): 40440 - Luquillo, PR 40450 - Manati, PR Service Area(s): 40460 - Maricao, PR Service Area(s): 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): 40530 - Orocovis, PR Service Area(s): 40540 - Patillas, PR Service Area(s): Service Area(s): 40550 - Penuelas, PR 40560 - Ponce, PR Service Area(s): Service Area(s): 40570 - Quebradillas, PR 40580 - Rincon, PR Service Area(s): 40590 - Rio Grande, PR Service Area(s): Service Area(s): 40610 - Sabana Grande, PR 40620 - Salinas, PR Service Area(s): 40630 - San German, PR Service Area(s): 40640 - San Juan, PR Service Area(s): Service Area(s): 40650 - San Lorenzo, PR Service Area(s): 40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR Service Area(s): Service Area(s): 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR 40740 - Viegues, PR Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR Service Area(s): Service Area(s): 40770 - Yauco, PR

Contrato Número

3 - 0 0 4

Omorpos DE SAV

Contract Number:

H5577

6/7/22, 3:54 PM

Plan ID:

029

Segment ID:

Contract Period:

2023

Plan Geographic Name:

Puerto Rico

Is this an Employer-Only

No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMSapproved 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

No

Services)?

Under this D-SNP, has the

state agreed to cover all

Medicare premiums and cost sharing for enrollees in your

D-SNP?

Yes

SECTION A: SECTION A-3

Participating Pharmacy

Website Address:

www.mcsclassicare.com

Formulary Website Address:

Physician Website Address:

www.mcsclassicare.com www.mcsclassicare.com

Customer Service Contact

Phone Number for Current

Medicare Beneficiaries:

(787)620-2530

(866)627-8183

Customer Service Contact

Local Phone Number for

Current Medicare

Beneficiaries:

Customer Service Contact

(866)627-8181

Phone Number for Prospective Medicare Beneficiaries:

Customer Service Contact

Local Phone Number for Prospective Medicare

(787)620-2528

Beneficiaries:

Customer Service Contact

Phone Number for Current

Part D Medicare

(866)627-8183

Beneficiaries:

Customer Service Contact

Local Phone Number for Current Part D Medicare

Beneficiaries:

(787)620-2530

MR

Contrato Número

POSDE

3/7/22, 3:54 PM	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
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	No



6/7/22, 3:54 PM PBP Data Report

are entered in Section B of the

PBP software)

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

Does the plan provide

No

Inpatient Hospital-Acute Services as a supplemental

benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required? Is a referral required for

Yes Yes

Inpatient Hospital-Acute

Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 1

Does the plan provide

No

Inpatient Hospital Psychiatric Services as a supplemental

benefit under Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

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

Contrato Número M OUR OS DE SALV Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Hospital Psychiatric benefit

period?

Original Medicare

Is authorization required?

Yes

Is a referral required for

No

Inpatient Psychiatric Hospital

Services?

Notes: Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #2 SNF - BASE 1

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

No

Part C?

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

Yes

SNF admission?

Indicate the Number of

Zero

Hospital Days Required Prior to SNF Admission (0-2):

Is there a service-specific

No

Pocket Cost?

Maximum Enrollee Out-of-

SECTION B: #2 SNF - BASE 2

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

No

Is there an enrollee

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit

Original Medicare

period?

Is authorization required?

Yes

Is a referral required for SNF

Yes

Services?

SECTION B: #3 CARDIAC AND PULMONARY

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REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation

Services as a supplemental benefit under Part C?

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

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

No

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee

No

Copayment?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Copayment?

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

Does the plan provide

Yes

Worldwide Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency



6/7/22, 3:54 PM PBP Data Report

Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency Mandatory

Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

Is there a Maximum Plan

No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

No

Is there an enrollee Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

No

Copayment?

Is authorization required?
Is a referral required for

Yes No

Partial Hospitalization?

Notes:

Preauthorization required through MCS Solutions,

except for Emergency and

Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific

No



Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home

Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide

Yes

Chiropractic Services as a supplemental benefit under

Part C?

Select enhanced benefit:

: Routine Care

Select type of benefit for

Mandatory

Routine Care:

Is this benefit unlimited for

No, indicate number

Routine Care?

Indicate number of visits for

6

Routine Care:

Select Routine Care

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

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Is there an enrollee

No

Deductible?

Is authorization required?

No

Is a referral required for

Yes

Chiropractic Services?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 2

Is authorization required?

Yes

Is a referral required for

No

Occupational Therapy

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required?

No

Is a referral required for

Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

Copayment?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 3

Is authorization required? Yes Is a referral required for No

Mental Health Specialty Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? No Is a referral required for Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

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

Health Care Professional

Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

Maximum Enrollee Out-of-

No

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6/7/22, 3:54 PM PBP Data Report

Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for No

Psychiatric Services?

Notes: Preauthorization required through MCS Solutions.

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes
Is a referral required for No

Physical Therapy and Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

Yes

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:

: 7a: Primary Care Physician

Services

: 7d: Physician Specialist

Services

: 7e1: Individual Sessions for Mental Health Specialty

Services

No

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training

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

Telehealth?

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SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 3

Is authorization required for

No

Additional Telehealth

Services?

Is a referral required for

No

Additional Telehealth

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

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SERVICES - BASE 4

Is authorization required?

Yes

Is a referral required for

Yes

Outpatient Diagnostic

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

Yes

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required for

Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for

No

Medicare-covered Observation Services?

Is a referral required for

Yes

Medicare-covered Outpatient

Hospital Services?

Is a referral required for

No



SMR

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

Yes

Is a referral required for

Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required?

No

Is a referral required for

No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

1

Does the plan provide

Yes

Outpatient Blood Services as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Three (3) Pint Deductible

Waived

Select type of benefit for Three (3) Pint Deductible

Mandatory

Waived:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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Is there an enrollee

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

No Is authorization required? Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for

Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide

Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit: Plan Approved Health-related

Location

Select type of benefit for Plan

Approved Health-related

Mandatory

Location:

Is this benefit unlimited for

No

number of trips for Plan Approved Health-related

Location?

Indicate number of trips for

26

Plan Approved Health-related Location:

Select Plan Approved Health-

Every year

related Location Trips

periodicity:

One-way

Select Type of Transportation

for Plan Approved Health-

related Location:

Contrato Número POSDE

: Medical Transport

Select Mode of Transportation

for Plan Approved Health-

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required? Is a referral required for

No No

Transportation Services?

Notes:

Transportation to Plan-

Approved Location provided by contracted transportation

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred Yes

vendors/manufacturers for Durable Medical Equipment

(DME)?

Is authorization required? Yes

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES

BASE 1

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

Is there an enrollee

No

Copayment?

Do you limit Diabetic

Yes

Supplies and Services to those from specified manufacturers?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Coinsurance?

Is there an enrollee

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No



Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of

6

Treatments:

Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Yes

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

Mandatory

Items:

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage amount: 0.00

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Does your Maximum Plan

Yes

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



Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

Are you offering Nicotine

No

Replacement Therapy (NRT) as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Does this cover all of the OTC

No

list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

This benefit is combined with the SSBCI Benefit Card. The combined amount appears in

Section D.

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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

No

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

Medicare-covered Zero Dollar

Preventive Services

Attestation

section.

: 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?

No

Is a referral required?

No

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

Does the plan provide the Annual Physical Exam as a No

Contrato Número

Yes

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

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including

Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

Massage*

Select type of benefit for

Health Education:

Mandatory

Select type of benefit for

Nutritional/Dietary Benefit:

Mandatory

6

Is this benefit unlimited for

Nutritional/Dietary Benefit?

Indicate number of visits for

Nutritional/Dietary Benefit:

Indicate setting for

Individual Sessions

: Physical Fitness

No, indicate number

Nutritional/Dietary Benefit: Select type of benefit for

Fitness Benefit:

Mandatory

Mandatory

Indicate type of Fitness

apply):

Benefit offered (Select all that

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

Hotline):

: Web/Phone-based Select the type of Remote Access Technologies offered technologies : Nursing Hotline (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for

Alternative Therapies?

No, indicate number

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Indicate number of visits 6

offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 3

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited? No Indicate limit for number of 6

sessions

Indicate the number of

Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 4

Is there a service-specific

No

Maximum Plan Benefit Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

Is there a service-specific No

Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

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

Defined Supplemental

Benefits?

Nutritional/Dietary Benefit Personal evaluation and diet

Notes: plan designed by licensed dietitian according to patient's

health needs, including exercise suggestions.

Fitness Benefit Notes:* Exercise and Nutrition

Education Interventions.

Member has access to fitness classes to promote physical



6/7/22, 3:54 PM PBP Data Report

activity and a healthier lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement faceto-face visits with a boardcertified physician to treat the most common conditions, such as allergies, flu, among

others.

Remote Access Technologies (Nursing Hotline) Notes:

Nursing Hotline.

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

Alternative Therapies Notes:* Foot reflexology is limited to

six (6) visits per year and must be ordered by a physician or

medical professional.

Therapeutic Massage Notes: Therapeutic Massage must be

No

No

ordered by a physician or medical professional.

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 No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No

Kidney Disease Education

Services?

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

Is there a service-specific No

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 No

Coinsurance?

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Is there an enrollee No

Deductible?

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

Is there an enrollee No

Copayment?

Is authorization required for No

Medicare-covered Glaucoma

Screening?

Is authorization required for No

Medicare-covered Diabetes Self-Management Training?

Is authorization required for No

Medicare-covered Barium

Enemas?

Is authorization required for No

Medicare-covered Digital

Rectal Exams?

Is authorization required for No

Medicare-covered EKG following Welcome Visit?

SECTION B: #14E OTHER MEDICARE-COVERED

PREVENTIVE SERVICES - BASE 4

Is a referral required for any No

Services?

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

Is there a Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

Is Authorization Required? Yes
Does the plan offer step Yes

therapy?

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D No

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 No

Preventive Dental Items as a

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Or POS DE SAY

supplemental benefit under

Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Yes

Comprehensive Dental Items as a supplemental benefit

under Part C?

Select enhanced benefits: : Non-routine Services

> : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

routine Services:

Mandatory

Is this benefit unlimited for

Non-routine Services?

Yes

Select type of benefit for

Diagnostic Services:

Mandatory

Is this benefit unlimited for

Diagnostic Services?

No, indicate number

Indicate number of visits for

Diagnostic Services:

1

Select the Diagnostic Services

periodicity:

Every six months

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

No, indicate number

Indicate number of visits for

Restorative Services:

1

Select the Restorative Services

periodicity:

Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Mandatory

Endodontics:

Is this benefit unlimited for

Endodontics?

Yes

Select type of benefit for

Periodontics:

Mandatory

Is this benefit unlimited for

Periodontics?

Yes

Select type of benefit for

Extractions:

Is this benefit unlimited for

Yes

Extractions?

Mandatory

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Contrato Número

Mandatory

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Yes

Prosthodontics, Other

Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type: Indicate Maximum Plan period 2100.00

Benefit Coverage amount:

Select the Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee No

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes Is a referral required for No

Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye

Yes

Exams as a supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited for

No, indicate number

Routine Eye Exams?

Indicate number of exams for

1

Routine Eye Exams:

Select the Routine Eye Exams

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit

DAINISTRACION Contrato Número

Coverage amount?

Is there a service-specific No Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

No Is there an enrollee

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Yes Does the plan provide

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses : Eyeglass 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 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eyeglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eyeglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit

Select the Maximum Plan

Yes

Coverage amount?

Plan-specified amount per

Benefit Coverage type: period



6/7/22, 3:54 PM

Do you offer a Combined Max

Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum

Plan Benefit Coverage

amount:

Select the Combined Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-ofNo

Yes

0.00

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

No

Is a referral required for

No

Eyewear?

Notes:

Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid

maximum amount.

Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Yes

Exams as a supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams

: Fitting/Evaluation for

Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory

Is this benefit unlimited for

Indicate number for Routine

No, indicate number

Routine Hearing Exams?

1

Hearing Exams:

Select Routine Hearing Exams

Every year

periodicity:

Select type of benefit for

Mandatory

SAMISTRACION SAMINES

Fitting/Evaluation for Hearing

Aid:

Is this benefit unlimited for Fitting/Evaluation for Hearing

No, indicate number

Aid?

Indicate number for

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit

No

1

Coverage amount? Is there an enrollee

No

Deductible?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit Yes

under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for

Mandatory

Hearing Aids (all types):

Is this benefit unlimited for

No, indicate number

Hearing Aids (all types)?

Indicate quantity for Hearing 2

Aids (all types):

Select Hearing Aids (all types) Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan Both ears combined

Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum Plan

Plan-specified amount per

SHINISTRACION Contrato Número POSDE

No

period Benefit Coverage type: 0.00 Indicate Maximum Plan

Benefit Coverage amount:

Indicate Maximum Plan Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? No Is a referral required for Yes

Hearing Aids?

Benefit and Maximum Plan Notes:

> Coverage Amount includes benefit for repair of devices.

This benefit is combined with

the eyewear maximum

amount.

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

Does your plan include MA No Uniformity Flexibility with

reductions in cost or additional benefits?

Do you offer Special Yes

Supplemental Benefits for the

Chronically III?

Select what type of benefit : Additional Benefits

your SSBCI includes:

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

Does your VBID/MA Yes

Uniformity Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your 1

Additional Benefits contain? (1-15)

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

Is this package applicable to

SSBCI

VBID or MA Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS 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 : Other 1 : Other 2 : Other 3 : Other 4 : Other 5

Crohn's disease or Ulcerative Other 1 Description:

colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive

pulmonary disease (COPD)

Severe mental retardation Other 4 Description: Moderate to Severe Autism Other 5 Description:

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

Is there a prerequisite for any

No

No

additional benefits for this

package?

Select all the Non-Medicare-: 13i: Non-Primarily Health covered additional benefits Related Benefits for the offered in this package: Chronically Ill

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

DEDUCTIBLE): PACKAGE #1 Are any benefits exempt from

the plan-level deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE OMINISTRACION Contrato Número POSDE

6/7/22, 3:54 PM PBP Data Report

AMOUNT): PACKAGE #1

No Is there a package level maximum coverage amount?

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

Notes:

The following SSBCI benefits will be offered: - SSBCI Card* w/monthly periodicity and rollover - Pest Control and General Supports for Living - Home Assistance Services w/quarterly periodicity - Transportation for Non-Medical Needs

The following general categories will be covered for the SSBCI Card:

- 1. Food, produce and prepared
- 2. General supports for daily living
- 3. Transportation to Non-Medical needs
- 4. OTC, Hygiene, personal care, first aid, hurricane preparedness items
- 5. Gasoline and auto repairs
- 6. Cleaning Products, Air Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances
- 7. Social needs benefits
- 8. Services supporting selfdirection
- 9. Copays and coinsurances for health services, supports for complementary therapies
- 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia



- 7. Diabetes
- 8. End-stage liver disease
- 9. End-stage renal disease

(ESRD)

10. Severe hematologic

disorders

- 11. HIV/AIDS
- 12. Chronic lung disorders
- 13. Chronic and disabling mental health conditions
- 14. Neurologic disorders
- 15. Stroke
- 16. Crohn's Disease
- 17. Ulcerative Colitis
- 18. Anemia
- 19. Chronic Obstructive

Pulmonary Disease (COPD)

20. Moderate to Severe

Autism

- 21. Severe Mental Retardation
- 22. Rheumatologic disease
- 23. Hx of cancer (Personal

history of cancer)

- 24. Hypertension
- 25. Valvular heart disease
- 26. Cerebrovascular disease
- 27. Chronic viral hepatitis C
- 28. Chronic liver disease
- 29. Neurodegenerative disease
- 30. Malnutrition and Cachexia
- 31. Obesity
- 32. Chronic kidney disease
- 33. Colostomy status
- 34. Non-pressure chronic

ulcer

35. Others (as identified).

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health : Food and Produce : Pest Control

Related Benefits for the

: Transportation for Non-

Medical Needs Chronically III includes:

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food

Yes

and Produce as a supplemental

benefit under Part C?

Mandatory

and Produce:

Is there a service-specific

Yes

Maximum Plan Benefit

Select type of benefit for Food



Coverage amount?

Indicate Maximum Plan

0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Food

No

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: This benefit is combined with

OTC. The combined amount appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC

Items.

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

Does the plan provide Pest

Yes

Control as a supplemental

benefit under Part C?

Mandatory

Select type of benefit for Pest Control:

Is there a service-specific

No

Maximum Plan Benefit

. . . .

Coverage amount? Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

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Copayment?

Is authorization required?

No

Is a referral required for Pest

No

Control?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL -BASE 3: PACKAGE #1

Notes:

Services listed in this category will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General Supports for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Does the plan provide

Yes

Transportation for Non-Medical Needs as a

supplemental benefit under

Part C?

Select enhanced benefit:

Plan-approved Location

Select type of benefit for Plan-

approved Location:

No

Mandatory

Is this benefit unlimited for number of trips for Plan-

approved Location?

Indicate number of trips for

0

Plan-approved Location:

Every year

Select Plan-approved Location Trips periodicity:

Select Type of Transportation

for Non-Medical Needs for

One-way

Plan-approved Location: Select Mode of Transportation

: Medical Transport : Other, Describe

for Non-Medical Need for Plan-approved Location:

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION

FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific

No



Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

No Is there an enrollee

Copayment?

No Is authorization required? Is a referral required for No

Transportation for Non-

Medical Needs?

Notes: Fleet includes 4-door sedans.

> minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the beneficiary qualifies for

SSBCI.

No

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

Does the plan provide General Yes

Supports for Living as a supplemental benefit under

Part C?

Select type of benefit for Mandatory

General Supports for Living:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee No

Coinsurance?

No Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No



General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes: Home Assistance - Twelve

(12) visits per year (three per quarter) for Home Assistance (Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance,

Hairstyling, Basic Gardening) and categories listed under

Pest Control.

Cell Phone Benefit - Cellular data plan to improve or maintain the health or overall function of the enrollee.

SECTION C: V/T - GENERAL - US

Do you offer a US No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-

NETWORK)

Is there an In-Network Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum Lower

Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?

Indicate In-Network 3400.00

Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply

to the In-Network Maximum

Enrollee Out-of-Pocket cost:

: In-Network Medicare-

covered benefits

Does the In-Network

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in

No

Yes

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Yes

6/7/22, 3:54 PM PBP Data Report

Supplemental Benefits with uniform cost sharing?

Select the number of 2

Combined Supplemental Benefit packages you are

offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare : 17b1: Contact Lenses

covered benefits are included : 17b2: Eyeglasses (lenses and

in your Combined frames)

Supplemental Benefit : 17b3: Eyeglass lenses package: : 17b4: Eyeglass frames : 18b1: Hearing Aids (all

types)
: Other

No

What is your combined

supplemental benefits mode of

delivery?

Other Description: Combined Eyewear and Hearing Allowance

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined Yes

Supplemental Benefits with a shared maximum plan benefit

amount?

Max Plan Benefit Amount: 500.00 Select Maximum Plan Benefit Every year

Coverage Amount Periodicity:

Supplemental Benefits with a

shared visit limit?

Do you offer Combined No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare

covered benefits are included

in your Combined Supplemental Benefit

package:

: 13b: Over-the-Counter

(OTC) Items

: 19b: Additional Benefits for

VBID/UF/SSBCI

What is your combined

supplemental benefits mode of

delivery?

Other Description: Combined SSBCI Card/OTC

benefit

: Other

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

No



6/7/22, 3:54 PM PBP Data Report

Do you offer Combined Yes Supplemental Benefits with a

shared maximum plan benefit amount?

Max Plan Benefit Amount: 60.00

Select Maximum Plan Benefit Every month

Coverage Amount Periodicity:

Do you offer Combined No

Supplemental Benefits with a

shared visit limit?

SECTION D: NOTES

Notes: Non-SSBCI eligible members

Yes

will receive full card allowance in OTC.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug

(Part D) benefit?

Defined Standard Select the type of drug benefit: Describe the components of : Standard Retail : Out-of-Network your pharmacy network (select all that apply): : 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

Do you pay for over-thecounter medications (OTCs) under the utilization management program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost

sharing Location/supply

amount(s) that apply:

: Standard Retail Cost Sharing

- 1 month Supply

: Standard Retail Cost Sharing

- 2 month Supply

: Standard Retail Cost Sharing

- 3 month Supply

Enter number of days for

Standard Retail Cost Sharing

1-month supply:

Enter number of days for Standard Retail Cost Sharing

2-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:

60

30

90

: Out-of-Network Pharmacy -

one month supply



6/7/22, 3:54 PM PBP Data Report

Enter number of days for Out- 30 of-Network Pharmacy 1-

month supply:

Select all Standard Mail-Order Cost Sharing Location/supply

amount(s) that apply:

supply month supply

31

No

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

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 1month 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 \$112

for the first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D No Benefits and/or Part D Rewards and Incentives under the VBID Model?

: Standard Mail-Order - 3-

90

: Long-Term Care Pharmacy -

1-month supply

Yes

Contrato Número

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PBP Data Report

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 037, SEGMENT

Module:

PBP

Requested By:

d3ua

PLAN SYSTEM INFORMATION

Last entry Date:

06/06/2022

PBP Software Version:

2023.01

Plan Ready for Upload

06/06/2022 05:31:41 PM SA

Timestamp:

Western Standard Time

MA BPT Timestamp:

06/06/2022 09:36:42 PM SA

Western Standard Time

PD BPT Timestamp:

06/06/2022 09:36:58 PM SA

Western Standard Time

Last Upload File Creation

06/06/2022 09:52:24 PM SA

Timestamp:

Western Standard Time

Upload Status:

06/06/2022 #02466

PLAN STATUS

Section A Status

Plan Ready for Upload

Section B1 Status

Completed

Section B2 Status

Completed

Section B3 Status

Completed

Section B4 Status Section B5 Status Completed

Section B6 Status

Completed Completed

Completed

Section B7 Status

Section B8 Status

Completed Completed

Section B9 Status Section B10 Status

Completed

Section B11 Status

Completed

Section B12 Status

Completed

Section B13 Status Section B14 Status

Completed Completed

Section B15 Status Section B16 Status

Completed Completed

Section B17 Status

Completed

Section B18 Status Section B19 Status Completed Completed

Section C Status

Completed Completed

Section D Status Section Mrx Status

Completed



6/7/22, 3:53 PM PBP Data Report

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing MCS Classicare

Name:

Organization Web Site: www.mcsclassicare.com
Plan Name: MCS Classicare Platino
(Planta (UMO D. SNR))

@Home (HMO D-SNP)

Organization Type: Local CCP
Plan Type: HMO

Enrollee Type:
Part A and Part B

Service Area(s):
40010 - Adjuntas, PR

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):

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

Service Area(s):

40080 - Arroyo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

Service Area(s):

Service Area(s):

40100 - Barranquitas, PR

40110 - Bayamon, PR

Service Area(s):

40120 - Cabo Rojo, PR

Service Area(s):

40130 - Caguas, PR

Service Area(s):

40140 - Camuy, PR

40145 - Canovanas, PR

Service Area(s):

Service Area(s):

40143 - Canovanas, R
40145 - Carolina, PR

Service Area(s):

40160 - Catano, PR

40170 - Cayey, PR

Service Area(s):

40180 - Ceiba, PR

Service Area(s):

40190 - Ciales, PR

Service Area(s):

40200 - Cidra, PR

Service Area(s):

40210 - Coamo, PR

Service Area(s):

Service Area(s):

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

Service Area(s):

40250 - Dorado, PR

Service Area(s):

40260 - Fajardo, PR

Service Area(s):

40265 - Florida, PR

Service Area(s): 40270 - Guanica, PR
Service Area(s): 40280 - Guayama, PR
Service Area(s): 40290 - Guayanilla, PR

Service Area(s): 40300 - Guaynabo, PR Service Area(s): 40310 - Gurabo, PR Service Area(s): 40320 - Hatillo, PR

Service Area(s): 40330 - Hormigueros, PR

PBP Data Report

Service Area(s): 40340 - Humacao, PR 40350 - Isabela, PR Service Area(s): 40360 - Jayuya, PR Service Area(s): Service Area(s): 40370 - Juana Diaz, PR 40380 - Juncos, PR Service Area(s): Service Area(s): 40390 - Lajas, PR 40400 - Lares, PR Service Area(s): 40410 - Las Marias, PR Service Area(s): 40420 - Las Piedras, PR Service Area(s): 40430 - Loiza, PR Service Area(s): 40440 - Luquillo, PR Service Area(s): 40450 - Manati, PR Service Area(s): Service Area(s): 40460 - Maricao, PR Service Area(s): 40470 - Maunabo, PR 40480 - Mayaguez, PR Service Area(s): 40490 - Moca, PR Service Area(s): 40500 - Morovis, PR Service Area(s): 40510 - Naguabo, PR Service Area(s): Service Area(s): 40520 - Naranjito, PR 40530 - Orocovis, PR Service Area(s): 40540 - Patillas, PR Service Area(s): Service Area(s): 40550 - Penuelas, PR 40560 - Ponce, PR Service Area(s): 40570 - Quebradillas, PR Service Area(s): 40580 - Rincon, PR Service Area(s): Service Area(s): 40590 - Rio Grande, PR 40610 - Sabana Grande, PR Service Area(s): Service Area(s): 40620 - Salinas, PR Service Area(s): 40630 - San German, PR 40640 - San Juan, PR Service Area(s): 40650 - San Lorenzo, PR Service Area(s): 40660 - San Sebastian, PR Service Area(s): Service Area(s): 40670 - Santa Isabel, PR 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): Service Area(s): 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR 40730 - Vega Baja, PR Service Area(s): 40740 - Viegues, PR Service Area(s): 40750 - Villalba, PR Service Area(s): Service Area(s): 40760 - Yabucoa, PR 40770 - Yauco, PR Service Area(s): Contract Number: H5577

Contrato Número

23 - 004

OLAOS DE SAN

Plan ID:

037

Segment ID:

0

Contract Period:

2023

Plan Geographic Name:

Puerto Rico

Is this an Employer-Only

No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMSapproved Continuation Area? No

Do you intend to participate in

Yes

the PLATINO program? Is this a Special Needs Plan?

Yes

Special Needs Plan Type:

Is this D-SNP plan a Medicare

Dual-Eligible

zero-dollar cost sharing plan (this does not apply to Part D No

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Yes

SECTION A: SECTION A-3

Participating Pharmacy

www.mcsclassicare.com

Website Address:

www.mcsclassicare.com www.mcsclassicare.com

Formulary Website Address:

(866)627-8183

Physician Website Address: **Customer Service Contact**

Phone Number for Current

Medicare Beneficiaries:

(787)620-2530

Customer Service Contact Local Phone Number for

Current Medicare

Beneficiaries:

(866)627-8181

Customer Service Contact Phone Number for Prospective

Medicare Beneficiaries:

Customer Service Contact

Local Phone Number for

(787)620-2528

Prospective Medicare Beneficiaries:

Customer Service Contact

(866)627-8183

Phone Number for Current Part D Medicare

Beneficiaries:

Customer Service Contact Local Phone Number for

Current Part D Medicare

Beneficiaries:

(787)620-2530

Contrato Número

8/7/22, 3:53 PM	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
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	No

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

No

Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Does this plan's Medicarecovered benefit cost sharing

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

Is there an enrollee No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required? Yes
Is a referral required for Yes

Inpatient Hospital-Acute

Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 1

Does the plan provide No

Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 2

Does this plan's Medicarecovered benefit cost sharing

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

Is there an enrollee No

Coinsurance?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 7



6/7/22, 3:53 PM PBP Data Report

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Hospital Psychiatric benefit

period?

Original Medicare

Is authorization required?

Yes

Is a referral required for

No

Inpatient Psychiatric Hospital

Services?

Notes:

Preauthorization required through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a

supplemental benefit under

Part C?

Do you allow less than 3 day

Yes

No

inpatient hospital stay prior to

SNF admission?

Indicate the Number of

Zero

Hospital Days Required Prior

to SNF Admission (0-2):

Is there a service-specific

No

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicarecovered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee

obtains care?

Is there an enrollee

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit

Original Medicare

period?

Is authorization required?

Yes

Is a referral required for SNF

Yes

Services?

SECTION B: #3 CARDIAC AND PULMONARY



No

REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation

Services as a supplemental

benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee

No

Copayment?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Copayment?

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

Does the plan provide

Yes

Worldwide Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

Worldwide Emergency



6/7/22, 3:53 PM PBP Data Report

Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency Mandatory

Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

Is there a Maximum Plan No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes: Coverage is managed through

reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee

No

No

Copayment?

Is authorization required? Yes
Is a referral required for No

Partial Hospitalization?

Notes: Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific No

Constituto Minnero

OPE OUROS DE

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?
Is a referral required for Home

Yes Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Yes

Copayment?

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

Mandatory

Routine Care:

Is this benefit unlimited for

No, indicate number

Routine Care?

Indicate number of visits for

6

Routine Care:

Select Routine Care

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

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6/7/22, 3:53 PM PBP Data Report

Is there an enrollee

Deductible?

No

Is authorization required? No Is a referral required for Yes

Chiropractic Services?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 2

Is authorization required? Yes Is a referral required for No

Occupational Therapy

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required? No Is a referral required for Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

No Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Contrato Número

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

Mental Health Specialty Services - Non-Physician?

Notes:

Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide

No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

No

Is a referral required for

Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

Is authorization required?

No

Is a referral required for Other

Yes

Health Care Professional

Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Contrato Número POSDE

6/7/22, 3:53 PM PBP Data Report

Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for No

Psychiatric Services?

Notes: Preauthorization required

through MCS Solutions.

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes
Is a referral required for No

Physical Therapy and Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

Yes

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:

: 7a: Primary Care Physician

Services

: 7d: Physician Specialist

Services

: 7e1: Individual Sessions for

Mental Health Specialty

Services

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training

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

Telehealth?

No





PBP Data Report 6/7/22, 3:53 PM

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required for

No

Additional Telehealth

Services?

Is a referral required for

No

Additional Telehealth

Services?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

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PBP Data Report 6/7/22, 3:53 PM

SERVICES - BASE 4

Yes Is authorization required? Yes Is a referral required for

Outpatient Diagnostic

Procedures/Test/Lab Services?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Yes Is authorization required? Is a referral required for Yes

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

No

Is there an enrollee

Deductible?

Is there an enrollee No

Copayment?

Is authorization required for Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for No

Medicare-covered Observation Services?

Is a referral required for Yes

Medicare-covered Outpatient

Hospital Services?

Is a referral required for No Contrato Número

6/7/22, 3:53 PM PBP Data Report

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? Yes
Is a referral required for Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required? No Is a referral required for No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

1

Does the plan provide Yes

Outpatient Blood Services as a supplemental benefit under

Part C?

Select enhanced benefit: : Three (3) Pint Deductible

Waived

No

Select type of benefit for

Three (3) Pint Deductible

Waived:

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Mandatory

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Is there an enrollee

No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for

Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide

Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit:

Plan Approved Health-related

Location

Mandatory

Select type of benefit for Plan

Approved Health-related

Location:

Is this benefit unlimited for

No

number of trips for Plan Approved Health-related

Location?

Indicate number of trips for

24

Plan Approved Health-related

Location:

Select Plan Approved Health-

Every year

related Location Trips

periodicity:

Select Type of Transportation

One-way

for Plan Approved Health-

related Location:

Contrato Número

Select Mode of Transportation

for Plan Approved Health-

: Medical Transport

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Transportation Services?

Notes:

Transportation to Plan-

Approved Location provided by contracted transportation

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred

Yes

vendors/manufacturers for Durable Medical Equipment

(DME)?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 1

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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Contrato Número

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

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

Is there a service-specific

Maximum Enrollee Out-of-

No

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

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

Is there an enrollee

No

Copayment?

Do you limit Diabetic

Yes

Supplies and Services to those from specified manufacturers?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

SHIMISTRACION

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of

6

Treatments:

Indicate Number of

Treatments periodicity:

Every year

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No

Is a referral required for

No

Yes

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 Mandatory

Items:

Is there a service-specific

Maximum Plan Benefit

Yes

Coverage amount?

Indicate Maximum Plan 0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Does your Maximum Plan

Yes

Benefit Coverage amount carry forward to the next

period if it is unused?



Contrato Número

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Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Are you offering Nicotine No Replacement Therapy (NRT)

as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

No Is there an enrollee

Copayment?

Does this cover all of the OTC No

list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: This benefit is combined with

> the SSBCI Benefit Card. The combined amount appears in

Section D.

No

Mandatory

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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: #13D OTHER 1 - BASE 1

Enter name of Service Home Bundle: Diapers, Cream, Ensure, Wipes & (Optional):

Others

Select type of benefit for Other 1:

Yes Is there a service-specific

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan 250.00

Benefit Coverage amount:

Select Maximum Plan Benefit Other, Describe

Coverage periodicity:

Contrato Número UROSO

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost?

SECTION B: #13D OTHER 1 - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?
Is a referral required for Other

No No

Services?

SECTION B: #13D OTHER 1 - BASE 3

Notes:

Home Bundle periodicity is

monthly.

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service

In-Home Foot Care

(Optional):

Select type of benefit for

Mandatory

Other 2:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Other

No

Services?

SECTION B: #13E OTHER 2 - BASE 3

Notes: 1 visit per quarter.

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

Medicare-covered Zero Dollar

Preventive Services

: I attest that there is no coinsurance, copayment, or

Attestation

deductible for all Original
Medicare preventive services
that are offered at zero dollar

that are offered at zero dollar

cost sharing.

No

Is authorization required?



No

Yes

Is a referral required?

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

Does the plan provide the Annual Physical Exam as a

supplemental benefit under

Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 1

Does the plan provide Other

Defined Supplemental Benefits as a benefit under

Part C?

Select enhanced benefit (Select all that apply):

:: 14c1: Health Education :: 14c2: Nutritional/Dietary

Benefit

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

Massage*

Select type of benefit for

Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for

Nutritional/Dietary Benefit?

No, indicate number

Indicate number of visits for

Nutritional/Dietary Benefit:

for 6

Indicate setting for

Nutritional/Dietary Benefit:

Individual Sessions

Select type of benefit for

Mandatory

Fitness Benefit:

Indicate type of Fitness

: Physical Fitness

Benefit offered (Select all that apply):

Mandatory

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

Hotline):

Select the type of Remote

Access Technologies offered
(Select all that apply):

Web/Phone-based technologies
: Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for

Mandatory

Alternative Therapies:

Is this benefit unlimited for

No, indicate number

Alternative Therapies?

Indicate number of visits offered for Alternative

6

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 3

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited? No Indicate limit for number of 6

sessions

Indicate the number of

Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

No

BENEFITS - BASE 4

Is there a service-specific

Maximum Plan Benefit Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

No Is there a service-specific

Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

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

Defined Supplemental

Benefits?

Nutritional/Dietary Benefit

Notes:

Personal evaluation and diet plan designed by licensed

dietitian according to patient's health needs, including

exercise suggestions. file:///C:/Users/id4198/OneDrive - Medical Card System Inc/Desktop/Transferencia Documentos IMDB-01/2023 Medicare Advantage/2023 HPMS R...

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Fitness Benefit Notes:* Exercise and Nutrition

Education Interventions. Member has access to fitness classes to promote physical activity and a healthier

lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-

certified physician to treat the most common conditions, such as allergies, flu, among

others.

Remote Access Technologies

Nursing Hotline.

(Nursing Hotline) Notes:

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

Alternative Therapies Notes:* Foot reflexology is limited to

six (6) visits per year and must be ordered by a physician or

medical professional.

Therapeutic Massage Notes: Therapeutic Massage must be

ordered by a physician or medical professional.

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

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Kidney Disease Education

Services?

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

Is there a service-specific

No

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

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #14E OTHER MEDICARE-COVERED

PREVENTIVE SERVICES - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required for

No

Medicare-covered Glaucoma

Screening?

Is authorization required for

No

Medicare-covered Diabetes Self-Management Training?

Is authorization required for

No

Medicare-covered Barium

Enemas?

Is authorization required for

No

Medicare-covered Digital

Rectal Exams?

Is authorization required for

No

Medicare-covered 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

No

Out-of-Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

Is Authorization Required?

Yes

Does the plan offer step

Yes

No

therapy?

Does the benefit step from

: Part B to Part B?

(select all that apply):

: Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D

home infusion drugs as part of

a bundled service as a

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Contrato Número

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mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

No

Preventive Dental Items as a supplemental benefit under

Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Yes

Comprehensive Dental Items as a supplemental benefit

under Part C?

Select enhanced benefits:

: Non-routine Services

: Diagnostic Services

: Restorative Services

: Endodontics : Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

Mandatory

routine Services:

Is this benefit unlimited for

Non-routine Services?

Yes

Select type of benefit for

Diagnostic Services:

Mandatory

Is this benefit unlimited for

Diagnostic Services?

No, indicate number

Indicate number of visits for

Diagnostic Services:

1

Select the Diagnostic Services

periodicity:

Every six months

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

No, indicate number

Indicate number of visits for

1

Restorative Services:

Select the Restorative Services

Every three years

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Mandatory

Endodontics:

Is this benefit unlimited for

Yes

Endodontics?

Select type of benefit for

Mandatory

Periodontics:

Is this benefit unlimited for

Yes

Periodontics?

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Contrato Número

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Select type of benefit for

Extractions:

Mandatory

Is this benefit unlimited for

Yes

Extractions?

Select type of benefit for

Mandatory

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Yes

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type:

period

Indicate Maximum Plan

2000.00

Benefit Coverage amount:

Select the Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee

No

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for

No

Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye

Yes

1

Exams as a supplemental

benefit under Part C?

Select enhanced benefit:

: Routine Eye Exams

Select type of benefit for Routine Eve Exams:

Mandatory

Is this benefit unlimited for

Routine Eye Exams?

Indicate number of exams for

Routine Eye Exams:

No, indicate number

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Select the Routine Eye Exams

periodicity:

Every year

Is there a service-specific

Maximum Plan Benefit

No

No

Coverage amount? Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Yes Does the plan provide

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses : Eyeglass 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

Yes

Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eyeglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eveglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Yes Is there a service-specific

Contrato Número

29/42

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type: Do you offer a Combined Max period Yes

Plan Benefit Coverage

Amount for all Eyewear?

0.00

Indicate Combined Maximum

Plan Benefit Coverage

amount:

Every year

Select the Combined Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for No

Eyewear?

Notes: Eyewear benefit maximum

> amount includes repair of eyewear. This benefit amount is combined with a hearing aid

maximum amount.

Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. WINISTRACION OF THE PROPERTY O

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Exams as a supplemental benefit under Part C?

Yes

Select enhanced benefits: : Routine Hearing Exams

Fitting/Evaluation for

Hearing Aid Mandatory

Select type of benefit for

Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing Exams?

No, indicate number

Indicate number for Routine 1 Contrato Número

Hearing Exams:

Select Routine Hearing Exams

periodicity:

Every year

Mandatory

No, indicate number

Select type of benefit for

Fitting/Evaluation for Hearing

Aid:

Is this benefit unlimited for

Fitting/Evaluation for Hearing

Aid?

Indicate number for 1

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

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

Is there an enrollee

Deductible?

No

No

No

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No

Hearing Exams?

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

Mandatory

Yes

Yes

Hearing Aids (all types):

Is this benefit unlimited for

No, indicate number

Hearing Aids (all types)?

Indicate quantity for Hearing 2

Aids (all types):

Select Hearing Aids (all types) Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Does the Maximum Plan Both ears combined

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Contrato Número

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Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type: Indicate Maximum Plan period 0.00

Benefit Coverage amount:

Indicate Maximum Plan

Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

No

Copayment?

Is there an enrollee

Nο

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? No Is a referral required for Yes

Hearing Aids?

Notes: Benefit and Maximum Plan

Coverage Amount includes benefit for repair of devices.

This benefit is combined with

the eyewear maximum

amount.

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

Does your plan include MA

No

Uniformity Flexibility with reductions in cost or

additional benefits?

Do you offer Special No

Supplemental Benefits for the

Chronically III?

Are you offering a VBID

No

Yes

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

: Value-Based Design

Flexibilities by Condition or

Contrato Número
23 - 00
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other interventions have you

been approved by CMMI to

offer?

: I attest that

Value-Based Insurance Design

Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE **PLANNING**

WHP Program Type (choose

: Medicare Health Risk

Socioeconomic Status

one or more):

Assessment

WHP Mode of Engagement

: Telephonic : In-Person

(choose one or more):

: Web-Based

Does your organization offer

Part C Rewards or Incentives for beneficiaries for the offer

of WHP Services?

No

No

Does your organization offer

provider incentives for

offering or engaging beneficiaries in WHP

activities?

Program Connectedness:

: Provider/Patient portals

Please check the way that

: Data Warehouses

advance care plans and/or

advance directives are

connected from your program

to access points of care.

Expected Number of

2324

Beneficiaries to be Engaged

Annually:

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

Does your VBID/MA

No

Uniformity Flexibility/SSBCI

benefit offer Part C reductions

in cost?

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

Does your VBID/MA

Yes

Uniformity Flexibility/SSBCI

benefit offer additional Part C

benefits?

How many packages do your

1

Additional Benefits contain?

(1-15)

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

Is this package applicable to

VBID

VBID or MA Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR

Contrato Número POSDE

VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology -

: Socioeconomic Status

Please choose one or both:

Select LIS reduction level:

: Dual-Eligible Status (for

territories)

Expected Number of Enrollees

to be Targeted:

2324

2324

Expected Number of Enrollees

CCS

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

No

additional benefits for this

package?

Select all the Non-Medicarecovered additional benefits

offered in this package:

: 13i: Non-Primarily Health Related Benefits for the

Chronically Ill

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

Are any benefits exempt from

No

the plan-level deductible?

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

Is there a package level

No

maximum coverage amount?

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

Notes:

The following SSBCI benefits

will be offered:

SSBCI Card* w/monthly periodicity and rollover
 Pest Control and General Supports for Living - Home

Assistance Services w/quarterly periodicity - Transportation for Non-

Medical Needs

The following general categories will be covered for the SSBCI Card:

1. Food, produce and prepared

foods

2. General supports for daily

living

3. Transportation to Non-

Medical needs

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4. OTC, Hygiene, personal care, first aid, hurricane preparedness items
5. Gasoline and auto repairs
6. Cleaning Products. Air

6. Cleaning Products, Air Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances

7. Social needs benefits

8. Services supporting self-direction

9. Copays and coinsurances for health services, supports for complementary therapies 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia
- 7. Diabetes
- 8. End-stage liver disease
- 9. End-stage renal disease (ESRD)
- 10. Severe hematologic disorders
- 11. HIV/AIDS
- 12. Chronic lung disorders
- 13. Chronic and disabling mental health conditions
- 14. Neurologic disorders
- 15. Stroke
- 16. Crohn's Disease
- 17. Ulcerative Colitis
- 18. Anemia
- 19. Chronic Obstructive

Pulmonary Disease (COPD)

- 20. Moderate to Severe Autism
- 21. Severe Mental Retardation
- 22. Rheumatologic disease
- 23. Hx of cancer (Personal history of cancer)
- 24. Hypertension
- 25. Valvular heart disease
- 26. Cerebrovascular disease



> 27. Chronic viral hepatitis C 28. Chronic liver disease

29. Neurodegenerative disease 30. Malnutrition and Cachexia

31. Obesity

32. Chronic kidney disease 33. Colostomy status

34. Non-pressure chronic

35. Others (as identified).

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit : Food and Produce your Non-Primarily Health : Pest Control

Related Benefits for the : Transportation for Non-

Chronically Ill includes: Medical Needs

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food Yes

and Produce as a supplemental

benefit under Part C?

Select type of benefit for Food

Mandatory

and Produce:

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

Yes

Indicate Maximum Plan

0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

This benefit is combined with Notes:

OTC. The combined amount

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> appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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

Does the plan provide Pest Control as a supplemental

Select type of benefit for Pest

benefit under Part C?

Mandatory

Control:

Is there a service-specific Maximum Plan Benefit

No

Yes

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Control?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL -**BASE 3: PACKAGE #1**

Notes: Services listed in this category

will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection

- Any of the services listed under "Home Assistance" (filed under "General Supports

for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Does the plan provide

Yes



Transportation for Non-Medical Needs as a

supplemental benefit under

Part C?

Select enhanced benefit:

Plan-approved Location

Select type of benefit for Plan-

Mandatory

approved Location:

Is this benefit unlimited for number of trips for Planapproved Location?

No

Indicate number of trips for

Plan-approved Location:

0

Select Plan-approved Location

Every year

Trips periodicity:

Select Type of Transportation

for Non-Medical Needs for Plan-approved Location:

One-way

Select Mode of Transportation for Non-Medical Need for

: Medical Transport : Other, Describe

Plan-approved Location:

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific

Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Transportation for Non-

Medical Needs?

Notes:

Fleet includes 4-door sedans,

minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the



beneficiary qualifies for

SSBCI.

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

Does the plan provide General Yes

Supports for Living as a supplemental benefit under

Part C?

Select type of benefit for

Mandatory

General Supports for Living:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

Coinsurance?

Is there an enrollee

No

No

Deductible?

Is there an enrollee

Copayment?

3. T

No

Is authorization required? No Is a referral required for No

General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes: Home Assistance - Twelve

(12) visits per year (three per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance, Hairstyling, Basic Gardening) and categories listed under

Pest Control.

SECTION C: V/T - GENERAL - US

Do you offer a US No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-

NETWORK)

Is there an In-Network Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum Lower

Contrato Número
23 - 04

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Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?

Indicate In-Network 3400.00

Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply : In-Network Medicareto the In-Network Maximum covered benefits

Enrollee Out-of-Pocket cost:

Does the In-Network Yes

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in

No

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Yes

Supplemental Benefits with uniform cost sharing?

Select the number of 2

Combined Supplemental Benefit packages you are

offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare

: 17b1: Contact Lenses : 17b2: Eyeglasses (lenses and

covered benefits are included

frames)

in your Combined Supplemental Benefit

: 17b3: Eyeglass lenses: 17b4: Eyeglass frames

: 18b1: Hearing Aids (all

types)

What is your combined supplemental benefits mode of

: Other

delivery?

package:

Other Description: Combined Eyewear and

Hearing Allowance

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

No

Yes

select in advance?

Do you offer Combined Supplemental Benefits with a

shared maximum plan benefit

amount?

Max Plan Benefit Amount: 1000.00

Contrato Número

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Contrato Número

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Select Maximum Plan Benefit

Coverage Amount Periodicity:

Every year

Do you offer Combined Supplemental Benefits with a No

shared visit limit?

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare

: 13b: Over-the-Counter

covered benefits are included

(OTC) Items

in vour Combined

: 19b: Additional Benefits for

Supplemental Benefit

VBID/UF/SSBCI

package:

What is your combined

: Other

supplemental benefits mode of

delivery?

Other Description: Combined SSBCI Card/OTC

benefit

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

No

select in advance?

Do you offer Combined

Supplemental Benefits with a shared maximum plan benefit

amount?

Yes

Max Plan Benefit Amount: 50.00

Select Maximum Plan Benefit

Coverage Amount Periodicity:

Every month

Do you offer Combined

Supplemental Benefits with a

shared visit limit?

No

SECTION D: NOTES

Notes: Non-SSBCI eligible members

> will receive full card allowance in OTC.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Yes

Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit: Defined Standard Describe the components of : Standard Retail your pharmacy network : Out-of-Network (select all that apply): : 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

Do you pay for over-the-

No

counter medications (OTCs)



under the utilization management program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost

sharing Location/supply

: Standard Retail Cost Sharing

- I month Supply

: Standard Retail Cost Sharing amount(s) that apply:

- 2 month Supply

: Standard Retail Cost Sharing

- 3 month Supply

Enter number of days for

Standard Retail Cost Sharing

1-month supply:

30

Enter number of days for Standard Retail Cost Sharing

2-month supply:

60

Enter number of days for Standard Retail Cost Sharing

90

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)

: Long-Term Care Pharmacy -

1-month supply

that apply:

Enter number of days for

Long-Term Care Pharmacy 1-

month supply:

Are all of the drugs on your

31

No formulary available with an

extended day supply?

Are any of the drugs available

at an extended day supply limited to a 1-month supply Yes

for the first fill?

SECTION RX: VBID - GENERAL

Are you offering Part D

No

Benefits and/or Part D Rewards and Incentives under

the VBID Model?

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 041, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

Last entry Date: 06/06/2022 PBP Software Version: 2023.01

Plan Ready for Upload 06/06/2022 05:32:12 PM SA

Timestamp: Western Standard Time

MA BPT Timestamp: 06/06/2022 09:36:43 PM SA

Western Standard Time

PD BPT Timestamp: 06/06/2022 09:36:58 PM SA

Western Standard Time

Last Upload File Creation 06/06/2022 09:52:24 PM SA

Timestamp: Western Standard Time Upload Status: 06/06/2022 #02466

PLAN STATUS

Section B18 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 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 B14 Status Completed
Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed

Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed



Completed

PBP Data Report

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing MCS Classicare

Name:

Organization Web Site: www.mcsclassicare.com
Plan Name: MCS Classicare Platino

Solido (HMO D-SNP)

Organization Type: Local CCP
Plan Type: HMO

Part A and Part B Enrollee Type: Service Area(s): 40010 - Adjuntas, PR Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR 40060 - Anasco, PR Service Area(s): Service Area(s): 40070 - Arecibo, PR Service Area(s): 40090 - Barceloneta, PR Service Area(s): 40120 - Cabo Rojo, PR 40140 - Camuy, PR Service Area(s):

40190 - Ciales, PR

40230 - Corozal, PR

40265 - Florida, PR

40270 - Guanica, PR

Service Area(s):

40290 - Guayanilla, PR

Service Area(s): 40320 - Hatillo, PR Service Area(s): 40330 - Hormigueros, PR

Service Area(s): 40350 - Isabela, PR
Service Area(s): 40360 - Jayuya, PR
Service Area(s): 40370 - Juana Diaz, PR

Service Area(s): 40390 - Lajas, PR Service Area(s): 40400 - Lares, PR

Service Area(s): 40410 - Las Marias, PR
Service Area(s): 40450 - Manati, PR
Service Area(s): 40460 - Maricao, PR
Service Area(s): 40480 - Mayaguez, PR

Service Area(s): 40490 - Moca, PR
Service Area(s): 40500 - Morovis, PR
Service Area(s): 40530 - Orocovis, PR
Service Area(s): 40550 - Penuelas, PR
Service Area(s): 40560 - Ponce, PR

Service Area(s): 40570 - Quebradillas, PR Service Area(s): 40580 - Rincon, PR

Service Area(s): 40610 - Sabana Grande, PR Service Area(s): 40630 - San German, PR Service Area(s): 40660 - San Sebastian, PR

Service Area(s): 40710 - Utuado, PR



Yes

No

Yes

www.mcsclassicare.com

(866)627-8183

40720 - Vega Alta, PR Service Area(s): Service Area(s): 40730 - Vega Baja, PR 40750 - Villalba, PR Service Area(s): 40770 - Yauco, PR Service Area(s):

Contract Number: H5577 Plan ID: 041 0 Segment ID: 2023 Contract Period:

Puerto Rico West 39 Plan Geographic Name:

No Is this an Employer-Only

plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-No approved Continuation Area?

Do you intend to participate in

the PLATINO program?

Is this a Special Needs Plan? Yes

Dual-Eligible Special Needs Plan Type:

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your

D-SNP?

SECTION A: SECTION A-3

Participating Pharmacy

Website Address:

Formulary Website Address: www.mcsclassicare.com www.mcsclassicare.com Physician Website Address:

Customer Service Contact Phone Number for Current

Medicare Beneficiaries:

Customer Service Contact (787)620-2530 Local Phone Number for

Current Medicare

Beneficiaries:

Customer Service Contact (866)627-8181

Phone Number for Prospective

Medicare Beneficiaries:

Customer Service Contact (787)620-2528

Local Phone Number for Prospective Medicare

Beneficiaries:

Customer Service Contact (866)627-8183

Phone Number for Current





the PBP?

6/7/22, 3:56 PM	
Part D Medicare Beneficiaries:	
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2530
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(866)627-8182
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	No



Do any of your outpatient services have tiered cost

No

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

No

Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required?

Yes

Is a referral required for

Yes

Inpatient Hospital-Acute

Services?

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

Does the plan provide

No

Inpatient Hospital Psychiatric Services as a supplemental

benefit under Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

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



Is there an enrollee

Coinsurance?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 7

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital Psychiatric benefit

Is authorization required?

period?

Yes

Is a referral required for

No

Yes

Inpatient Psychiatric Hospital

Services?

Notes: Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled No Nursing Facility Services as a

supplemental benefit under

Part C?

Do you allow less than 3 day

inpatient hospital stay prior to SNF admission?

Indicate the Number of Zero

Hospital Days Required Prior to SNF Admission (0-2):

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

- . .

Is there an enrollee No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee No

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit Original Medicare

period?



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

Services?

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

Does the plan provide Cardiac No 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 No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes
Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee No

Copayment?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT

COVERAGE - BASE 1

Does the plan provide Yes

Contrato Número

Worldwide Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency

Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

Is there a Maximum Plan

No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee Out-of-

No

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes: Coverage is managed through

reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific No Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee No

Copayment?

Is authorization required? Yes
Is a referral required for No

Partial Hospitalization?

Notes: Preauthorization required

through MCS Solutions,

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except for Emergency and Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home

Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide

Yes

Chiropractic Services as a supplemental benefit under

Part C?

Select enhanced benefit:

Routine Care

Select type of benefit for

Mandatory

Routine Care:

Is this benefit unlimited for

No, indicate number

Routine Care?

Indicate number of visits for

6

Routine Care:

Select Routine Care

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

No

Is there an enrollee

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

Is authorization required? No Is a referral required for Yes

Chiropractic Services?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes Is a referral required for No

Occupational Therapy

Services?

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

No

Is there a service-specific

Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required? No Is a referral required for Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 3

Is authorization required? Yes Is a referral required for No

Mental Health Specialty Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? No
Is a referral required for Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

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

Health Care Professional



PBP Data Report 6/7/22, 3:56 PM

Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes Is a referral required for No

Psychiatric Services?

Notes: Preauthorization required

through MCS Solutions.

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes Is a referral required for No

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 Yes

services?

Select the Medicare-covered

benefits that may have

Additional Telehealth Benefits

available:

: 7a: Primary Care Physician

Services

: 7d: Physician Specialist

Services

: 7e1: Individual Sessions for Mental Health Specialty

Services

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training POSDES

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost for Additional

Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 3

Is authorization required for

No

Additional Telehealth

Services?

Is a referral required for

No

Additional Telehealth

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required?

No

Is a referral required for

No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee

No



Deductible?

Is there an enrollee No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 4

Yes Is authorization required? Is a referral required for Yes

Outpatient Diagnostic

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

No Is there an enrollee

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Yes

Outpatient

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required for Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for No

Medicare-covered Observation Services?



Is a referral required for

Yes Medicare-covered Outpatient

Hospital Services?

6/7/22, 3:56 PM

Is a referral required for

No

Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

Yes

Is a referral required for

Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required?

No

Is a referral required for

No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Does the plan provide

Yes

Outpatient Blood Services as a supplemental benefit under

Part C?

Select enhanced benefit:

: Three (3) Pint Deductible

Waived

Select type of benefit for

Mandatory

Three (3) Pint Deductible

POSDE

Contrato Número

No

Waived:

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit: Plan Approved Health-related

Location Mandatory

Select type of benefit for Plan

Approved Health-related

Location:

Is this benefit unlimited for No

number of trips for Plan Approved Health-related

Location?

Indicate number of trips for 30

Plan Approved Health-related

Location:

Select Plan Approved Health-

related Location Trips

Every year



periodicity:

Select Type of Transportation

One-way

for Plan Approved Health-

related Location:

Select Mode of Transportation

: Medical Transport

for Plan Approved Health-

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

Copayment?

No

Is authorization required? Is a referral required for

No No

Transportation Services?

Notes: Transportation to Plan-

> Approved Location provided by contracted transportation

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred

Yes

vendors/manufacturers for Durable Medical Equipment

(DME)?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

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PBP Data Report 6/7/22, 3:56 PM

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 3

Is authorization required? Yes

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 2

Is there an enrollee No

Copayment?

Do you limit Diabetic Yes

Supplies and Services to those from specified manufacturers?

Yes Is authorization required?

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

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Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? No Is a referral required for No

Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Mandatory

Number of Treatments:

Is this benefit unlimited for No

Number of Treatments?

Indicate limit for Number of 6

Treatments:

Indicate Number of Every year

Treatments periodicity:

Is there a service-specific No

Maximum Plan Benefit Coverage amount?

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? No Is a referral required for No

Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

Yes

Does the plan provide Over-The-Counter (OTC) Items as a

supplemental benefit under

Part C?

Select type of benefit for OTC Mandatory

Items:

Is there a service-specific Yes

Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan 0.00

Benefit Coverage amount:

Select Maximum Plan Benefit Every month

Coverage periodicity:

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PBP Data Report 6/7/22, 3:56 PM

Does your Maximum Plan Yes 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)

No

No

as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2 Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

Does this cover all of the OTC No

list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes: This benefit is combined with

> the SSBCI Benefit Card. The combined amount appears in

Section D.

No

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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? No Is a referral required? No Contrato Número

No

Yes

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

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

Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 1

Does the plan provide Other

Defined Supplemental Benefits as a benefit under

Part C?

Select enhanced benefit : 14c1: Health Education (Select all that apply): : 14c2: Nutritional/Dietary

Benefit

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

No, indicate number

Individual Sessions

: Physical Fitness

Massage*

Select type of benefit for

Health Education:

Mandatory

Select type of benefit for

Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

Indicate number of visits for

Nutritional/Dietary Benefit:

6

Indicate setting for

Nutritional/Dietary Benefit:

nt:

Select type of benefit for

Fitness Benefit:

Mandatory

Mandatory

Indicate type of Fitness

Benefit offered (Select all that

apply):

Select type of benefit for

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

Hotline):

Select the type of Remote : Web/Phone-based Access Technologies offered (Select all that apply): : Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for Mandatory

Alternative Therapies:

Is this benefit unlimited for Alternative Therapies?

No, indicate number

Indicate number of visits

6

offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 3

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited? No Indicate limit for number of 6

sessions

Indicate the number of

Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 4

Is there a service-specific

No

Maximum Plan Benefit Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

Is there a service-specific

No

Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee

No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

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

Is a referral required for Other Defined Supplemental

Benefits?

Nutritional/Dietary Benefit

Notes:

Personal evaluation and diet plan designed by licensed

dietitian according to patient's health needs, including exercise suggestions.

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Fitness Benefit Notes:*

Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier

lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:* Video doctor visits are intended to complement faceto-face visits with a boardcertified physician to treat the most common conditions, such as allergies, flu, among

others.

Remote Access Technologies

Nursing Hotline.

(Nursing Hotline) Notes:

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

Alternative Therapies Notes:*

Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.

Therapeutic Massage Notes:

Therapeutic Massage must be ordered by a physician or medical professional.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Kidney Disease Education

Services?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost for Other

Medicare-covered Preventive

Services?



No

SECTION B: #14E OTHER MEDICARE-COVERED

PREVENTIVE SERVICES - BASE 2

Coinsurance?

Is there an enrollee

Is there an enrollee No

Deductible?

SECTION B: #14E OTHER MEDICARE-COVERED

PREVENTIVE SERVICES - BASE 3

Is there an enrollee No

Copayment?

Is authorization required for No

Medicare-covered Glaucoma

Screening?

Is authorization required for No

Medicare-covered Diabetes Self-Management Training?

Is authorization required for No

Medicare-covered Barium

Enemas?

Is authorization required for

Medicare-covered Digital

Rectal Exams?

Is authorization required for

Medicare-covered EKG

following Welcome Visit?

SECTION B: #14E OTHER MEDICARE-COVERED

PREVENTIVE SERVICES - BASE 4

Is a referral required for any

Services?

No

No

No

No

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

Is there a Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

Is Authorization Required? Yes Does the plan offer step Yes

therapy?

: Part B to Part B? Does the benefit step from Part D to Part B? (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

No



mandatory supplemental

benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide

No

Yes

Preventive Dental Items as a supplemental benefit under

Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide

Comprehensive Dental Items as a supplemental benefit

under Part C?

Select enhanced benefits: : Non-routine Services

: Diagnostic Services

: Restorative Services

: Endodontics : Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

routine Services:

Mandatory

Yes

1

Is this benefit unlimited for

Non-routine Services?

Select type of benefit for

Diagnostic Services:

Mandatory

Is this benefit unlimited for

Diagnostic Services?

Indicate number of visits for

Select the Diagnostic Services

Diagnostic Services:

Every six months

No, indicate number

periodicity:

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

No, indicate number

Indicate number of visits for

1

Restorative Services:

Select the Restorative Services Every three years

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for

Endodontics:

Mandatory

Is this benefit unlimited for

Yes

Endodontics?

Select type of benefit for

Mandatory

Periodontics:

Is this benefit unlimited for

Yes

Periodontics?



PBP Data Report 6/7/22, 3:56 PM

Select type of benefit for

Extractions:

Mandatory

Is this benefit unlimited for

Yes

Extractions?

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Yes

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount?

Plan-specified amount per Select the Maximum Plan

Benefit Coverage type: Indicate Maximum Plan

period 3000.00

Benefit Coverage amount:

Select the Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee

No

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Is a referral required for

Yes No

Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye

Yes

1

Exams as a supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for

Is this benefit unlimited for

Mandatory

Routine Eye Exams:

No, indicate number

Routine Eye Exams?

Indicate number of exams for

Routine Eye Exams:



Select the Routine Eye Exams

periodicity:

Every year

Is there a service-specific

Maximum Plan Benefit Coverage amount?

No

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

No

Is a referral required for Eye

No

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Yes

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses

: Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Mandatory

Is this benefit unlimited for

Contact lenses?

Yes

Contact ichses?

Select type of benefit for

Eyeglasses (lenses and

frames):

Is this benefit unlimited for

Yes

Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eyeglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eyeglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific

Yes



Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type:

period Yes

Do you offer a Combined Max

Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum

750.00

Plan Benefit Coverage

amount:

Select the Combined

Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

No

Is a referral required for

No

Eyewear?

Notes: Eyewear benefit maximum

> amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Exams as a supplemental benefit under Part C?

Yes

Select enhanced benefits:

Routine Hearing Exams

: Fitting/Evaluation for

Hearing Aid

Select type of benefit for Routine Hearing Exams:

Mandatory

Is this benefit unlimited for

No, indicate number

Routine Hearing Exams?

Indicate number for Routine

1

Hearing Exams:

Select Routine Hearing Exams

Every year



PBP Data Report 6/7/22, 3:56 PM

periodicity:

Select type of benefit for

Mandatory

Fitting/Evaluation for Hearing

Aid:

Is this benefit unlimited for

No, indicate number

Fitting/Evaluation for Hearing

Indicate number for

Aid?

1

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there an enrollee

No

Deductible?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing

Yes

Aids as a supplemental benefit under Part C?

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for

Mandatory

Hearing Aids (all types):

Is this benefit unlimited for

No, indicate number

Hearing Aids (all types)?

2

Indicate quantity for Hearing

Aids (all types):

Select Hearing Aids (all types)

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit

Yes

Coverage amount?

Does the Maximum Plan

Both ears combined

Benefit Coverage Amount



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apply per ear or for both ears

combined?

Select the Maximum Plan Plan-specified amount per

Benefit Coverage type: period Indicate Maximum Plan 2500.00

Benefit Coverage amount:

Indicate Maximum Plan Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific No Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? No
Is a referral required for Yes

Hearing Aids?

Notes: Benefit and Maximum Plan

Coverage Amount includes benefit for repair of devices.

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

Does your plan include MA No

Uniformity Flexibility with reductions in cost or additional benefits?

Do you offer Special Yes

Supplemental Benefits for the

Chronically III?

Select what type of benefit : Additional Benefits

your SSBCI includes:

SECTION B: #19B ADDITIONAL BENEFITS FOR

VBID/UF/SSBCI

Does your VBID/MA Yes

Uniformity Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your 1 Additional Benefits contain?

(1-15)

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

Is this package applicable to SSBCI



VBID or MA Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS 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 : Other 1 : Other 2 : Other 3 : Other 4 : Other 5

Other 1 Description: Crohn's disease or Ulcerative

colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive

pulmonary disease (COPD)

Other 4 Description: Severe mental retardation Other 5 Description: Moderate to Severe Autism

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

Is there a prerequisite for any

No

additional benefits for this

package?

Select all the Non-Medicare-: 13i: Non-Primarily Health Related Benefits for the covered additional benefits

offered in this package: Chronically III

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

Are any benefits exempt from

No

the plan-level deductible?

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



Is there a package level maximum coverage amount?

No

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

Notes:

The following SSBCI benefits will be offered:
- SSBCI Card* w/monthly periodicity and rollover
- Pest Control and General Supports for Living - Home Assistance Services w/quarterly periodicity
- Transportation for Non-Medical Needs

The following general categories will be covered for the SSBCI Card:

- 1. Food, produce and prepared foods
- 2. General supports for daily living
- 3. Transportation to Non-Medical needs
- 4. OTC, Hygiene, personal care, first aid, hurricane preparedness items
- 5. Gasoline and auto repairs
- 6. Cleaning Products, Air Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances
- 7. Social needs benefits
- 8. Services supporting self-direction
- 9. Copays and coinsurances for health services, supports for complementary therapies 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia
- 7. Diabetes
- 8. End-stage liver disease



9. End-stage renal disease (ESRD)

10. Severe hematologic disorders

11. HIV/AIDS

- 12. Chronic lung disorders
- 13. Chronic and disabling mental health conditions
- 14. Neurologic disorders
- 15. Stroke
- 16. Crohn's Disease
- 17. Ulcerative Colitis
- 18. Anemia
- 19. Chronic Obstructive

Pulmonary Disease (COPD)

20. Moderate to Severe

Autism

- 21. Severe Mental Retardation
- 22. Rheumatologic disease
- 23. Hx of cancer (Personal

history of cancer)

- 24. Hypertension
- 25. Valvular heart disease
- 26. Cerebrovascular disease
- 27. Chronic viral hepatitis C
- 28. Chronic liver disease
- 29. Neurodegenerative disease
- 30. Malnutrition and Cachexia
- 31. Obesity
- 32. Chronic kidney disease
- 33. Colostomy status
- 34. Non-pressure chronic ulcer

35. Others (as identified).

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit

: Food and Produce

your Non-Primarily Health

: Pest Control

Related Benefits for the Chronically III includes:

: Transportation for Non-

Medical Needs

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental

Select type of benefit for Food

Yes

benefit under Part C?

remental

benefit under Part C?

Mandatory

and Produce:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes



Indicate Maximum Plan

0.00

Benefit Coverage amount:

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND

PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Food

No

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND

PRODUCE - BASE 3: PACKAGE #1

Notes:

This benefit is combined with OTC. The combined amount appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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

BASE 1: PACKAGE #1

Does the plan provide Pest

Yes

Control as a supplemental benefit under Part C?

Select type of benefit for Pest

Mandatory

Control:

Is there a service-specific

No

Maximum Plan Benefit

Coverage amount?

Is there a service-specific

Maximum Enrollee Out-of-

No

Pocket Cost?

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

BASE 2: PACKAGE #1

Is there an enrollee

Is there an enrollee

No

Coinsurance?

No

Deductible?

Is there an enrollee

No

Copayment?



Contrato Número

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

Control?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL -**BASE 3: PACKAGE #1**

Services listed in this category Notes:

will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General Supports

for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Does the plan provide Yes

Transportation for Non-Medical Needs as a supplemental benefit under

Part C?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-

approved Location:

Mandatory

No

0

Is this benefit unlimited for number of trips for Plan-

approved Location?

Indicate number of trips for

Plan-approved Location:

Every year

Trips periodicity:

Select Type of Transportation for Non-Medical Needs for

Select Plan-approved Location

Plan-approved Location:

Select Mode of Transportation for Non-Medical Need for

Plan-approved Location:

One-way

: Medical Transport : Other. Describe

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific Maximum Plan Benefit

No

Coverage amount? Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

No





Contrato Namero

Is there an enrollee

Coinsurance?

No

Is there an enrollee

No

Deductible?

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for

No

Transportation for Non-

Medical Needs?

Fleet includes 4-door sedans, Notes:

> minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the beneficiary qualifies for

SSBCI.

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

Does the plan provide General Yes

Supports for Living as a supplemental benefit under

Part C?

Select type of benefit for

Mandatory

General Supports for Living:

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for No

General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL



SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes: Home Assistance - Twelve

(12) visits per year (three per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance, Hairstyling, Basic Gardening) and categories listed under

Pest Control.

SECTION C: V/T - GENERAL - US

Do you offer a US

No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan

No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (INNETWORK)

Is there an In-Network

Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum

Lower

Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?

Indicate In-Network

3400.00

Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network Maximum

: In-Network Medicare-

n-Network Maximum covered benefits

Enrollee Out-of-Pocket cost:

Does the In-Network

Yes

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in

No

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined

Yes

Supplemental Benefits with uniform cost sharing?

Select the number of

1

Combined Supplemental

Benefit packages you are

offering?

SECTION D: COMBINED BENEFITS #1



6/7/22, 3:56 PM

Select which non-Medicare covered benefits are included

in your Combined Supplemental Benefit

package:

: 13b: Over-the-Counter

(OTC) Items

: 19b: Additional Benefits for

PBP Data Report

VBID/UF/SSBCI

What is your combined

supplemental benefits mode of

delivery?

Other Description:

: Other

Combined SSBCI Card/OTC

benefit No

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined

Supplemental Benefits with a shared maximum plan benefit

amount?

Max Plan Benefit Amount:

Select Maximum Plan Benefit

Coverage Amount Periodicity:

Do you offer Combined

Supplemental Benefits with a

shared visit limit? **SECTION D: NOTES**

Notes:

230.00

Yes

Every month

No

Non-SSBCI eligible members

will receive full card allowance in OTC.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit:

Describe the components of your pharmacy network

(select all that apply):

Defined Standard

Yes

: Standard Retail

: Out-of-Network

: Standard Mail-Order

: Long-Term Care

Sponsor attests that it will comply with 42 CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-

counter medications (OTCs)

under the utilization management program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

No

Select all Standard Retail Cost

sharing Location/supply amount(s) that apply:

: Standard Retail Cost Sharing

- 1 month Supply

: Standard Retail Cost Sharing



- 2 month Supply : Standard Retail Cost Sharing - 3 month Supply Enter number of days for 30 Standard Retail Cost Sharing 1-month supply: Enter number of days for 60 Standard Retail Cost Sharing 2-month supply: 90 Enter number of days for Standard Retail Cost Sharing 3-month supply: Select all Out-of-Network : Out-of-Network Pharmacy -Pharmacy Location/supply one month supply amount(s) that apply: 30 Enter number of days for Outof-Network Pharmacy 1month supply: Select all Standard Mail-Order : Standard Mail-Order - 3-Cost Sharing Location/supply month supply amount(s) that apply: Enter number of days for 90 Standard Mail-Order Cost Sharing 3-month supply: Select the Long-Term Care Pharmacy one month 1-month supply

: Long-Term Care Pharmacy -

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

Long-Term Care Pharmacy 1-

Location/supply amount(s)

Enter number of days for

that apply:

month supply:

No

31

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

Yes

SECTION RX: VBID - GENERAL

Are you offering Part D No Benefits and/or Part D Rewards and Incentives under the VBID Model?

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 046, SEGMENT 0

Module: PBP
Requested By: d3ua
PLAN SYSTEM INFORMATION

Last entry Date: 06/06/2022 PBP Software Version: 2023.01

Plan Ready for Upload 06/06/2022 05:33:08 PM SA Timestamp: Western Standard Time

MA BPT Timestamp: 06/06/2022 09:36:44 PM SA

Western Standard Time

PD BPT Timestamp: 06/06/2022 09:37:00 PM SA

Western Standard Time

Last Upload File Creation
Timestamp:

Upload Status:

06/06/2022 09:52:24 PM SA
Western Standard Time
06/06/2022 #02466

PLAN STATUS

Section B14 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 Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed

Section B15 Status Completed
Section B16 Status 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

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing

MCS Classicare

Name:

Organization Web Site:

www.mcsclassicare.com

Plan Name:

MCS Classicare Platino Total

(HMO D-SNP)

Organization Type:

Local CCP

Plan Type:

HMO

Enrollee Type:

Part A and Part B

Service Area(s):

40010 - Adjuntas, PR

Service Area(s):

40020 - Aguada, PR

Service Area(s):

40030 - Aguadilla, PR

Service Area(s):

40040 - Aguas Buenas, PR

Service Area(s):

40050 - Aibonito, PR

Service Area(s):

40060 - Anasco, PR

Service Area(s):

40070 - Arecibo, PR

Service Area(s):

40080 - Arroyo, PR

Service Area(s):

40090 - Barceloneta, PR

Service Area(s):

40100 - Barranquitas, PR

Service Area(s):

40110 - Bayamon, PR

Service Area(s): Service Area(s): 40120 - Cabo Rojo, PR

40130 - Caguas, PR

Service Area(s): Service Area(s): 40140 - Camuy, PR 40145 - Canovanas, PR

Service Area(s):

40150 - Carolina, PR

Service Area(s):

40160 - Catano, PR 40170 - Cayey, PR

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

40180 - Ceiba, PR

Service Area(s):

40190 - Ciales, PR

Service Area(s): Service Area(s): 40200 - Cidra, PR 40210 - Coamo, PR

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

40220 - Comerio, PR 40230 - Corozal, PR

Service Area(s):

40240 - Culebra, PR

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

40250 - Dorado, PR 40260 - Fajardo, PR

Service Area(s):

40265 - Florida, PR

Service Area(s):

40270 - Guanica, PR

Service Area(s): Service Area(s): 40280 - Guayama, PR 40290 - Guayanilla, PR

Service Area(s): Service Area(s): 40300 - Guaynabo, PR 40310 - Gurabo, PR

Service Area(s):

40320 - Hatillo, PR

Service Area(s):

40330 - Hormigueros, PR



PBP Data Report

6/7/22.	3:56	PM

40340 - Humacao, PR Service Area(s): Service Area(s): 40350 - Isabela, PR Service Area(s): 40360 - Jayuya, PR 40370 - Juana Diaz, PR Service Area(s): 40380 - Juncos, PR Service Area(s): 40390 - Lajas, PR Service Area(s): 40400 - Lares, PR Service Area(s): Service Area(s): 40410 - Las Marias, PR Service Area(s): 40420 - Las Piedras, PR Service Area(s): 40430 - Loiza, PR 40440 - Luquillo, PR Service Area(s): 40450 - Manati, PR Service Area(s): Service Area(s): 40460 - Maricao, PR 40470 - Maunabo, PR Service Area(s): 40480 - Mayaguez, PR Service Area(s): 40490 - Moca, PR Service Area(s): Service Area(s): 40500 - Morovis, PR Service Area(s): 40510 - Naguabo, PR 40520 - Naranjito, PR Service Area(s): Service Area(s): 40530 - Orocovis, PR 40540 - Patillas, PR Service Area(s): Service Area(s): 40550 - Penuelas, PR 40560 - Ponce, PR Service Area(s): 40570 - Quebradillas, PR Service Area(s): Service Area(s): 40580 - Rincon, PR 40590 - Rio Grande, PR Service Area(s): 40610 - Sabana Grande, PR Service Area(s): 40620 - Salinas, PR Service Area(s): 40630 - San German, PR Service Area(s): Service Area(s): 40640 - San Juan, PR 40650 - San Lorenzo, PR Service Area(s): 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 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR Service Area(s): Service Area(s): 40740 - Vieques, PR Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR 40770 - Yauco, PR Service Area(s):

THE GUADS DE SALIS

SHINISTRACION

Contrato Número

Contract Number:

H5577

file:///C:/Users/id4198/OneDrive - Medical Card System Inc/Desktop/Transferencia Documentos IMDB-01/2023 Medicare Advantage/2023 HPMS Re...

046 Plan ID: 0 Segment ID: Contract Period: 2023

Puerto Rico Plan Geographic Name:

Is this an Employer-Only No

plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-No approved Continuation Area?

Do you intend to participate in Yes

the PLATINO program?

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)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Yes

Yes

SECTION A: SECTION A-3

Participating Pharmacy

Website Address:

www.mcsclassicare.com

Formulary Website Address: www.mcsclassicare.com Physician Website Address: www.mcsclassicare.com

Customer Service Contact Phone Number for Current

Medicare Beneficiaries:

Customer Service Contact Local Phone Number for

Current Medicare

Beneficiaries:

(787)620-2530

(866)627-8183

Customer Service Contact Phone Number for Prospective

Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Prospective Medicare

Beneficiaries:

Customer Service Contact Phone Number for Current

Part D Medicare Beneficiaries:

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

(866)627-8181

(787)620-2528

(866)627-8183

(787)620-2530

Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-4 Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Medicare Beneficiaries: Customer Service Contact Local TTY for Current Medicare Beneficiaries: Customer Service Contact Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Service Contact TTY for Current Part D Medicare Beneficiaries: SECTION A: SECTION A-5 Is your organization filing a standard bid for Section C of the PBP? SECTION A: SECTION A-6 Is your organization filing a No	Da
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Medicare Beneficiaries: Customer Service Contact Local TTY for Current Medicare Beneficiaries: Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact Local TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Sustomer Service Contact TTY for Current Part D Medicare Beneficiaries: Su	
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TTY for Current Medicare Beneficiaries: Customer Service Contact Local TTY for Current Medicare Beneficiaries: Customer Service Contact TTY for Prospective Medicare Beneficiaries: Customer Service Contact Local TTY for Prospective Medicare Beneficiaries: Customer Service Contact Local TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: 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	
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TTY for Prospective Medicare Beneficiaries: Customer Service Contact Local TTY for Prospective Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: 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	
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TTY for Current Part D Medicare Beneficiaries: Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: 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	
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TTY for Prospective Part D Medicare Beneficiaries: Customer Service Contact TTY for Current Part D Medicare Beneficiaries: 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	
TTY for Current Part D Medicare Beneficiaries: 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 B of the PBP? Is your organization filing a standard bid for Section C of the PBP? SECTION A: SECTION A-6	
standard bid for Section C of the PBP? SECTION A: SECTION A-6	
Is your organization filing a No	
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

No

Inpatient Hospital-Acute

Services as a supplemental benefit under Part C?

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

What is your Inpatient

Original Medicare

Hospital-Acute benefit

period?

Is authorization required?

Yes

Is a referral required for

Yes

Inpatient Hospital-Acute

Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 1

Does the plan provide

No

No

Inpatient Hospital Psychiatric

Services as a supplemental

benefit under Part C?

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

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

Does this plan's Medicare-

No

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

Is there an enrollee

No

Coinsurance?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATI

BASE 7

Is there an enrollee

Deductible?

No

Is there an enrollee

No

Yes

No

No

Yes

Zero

No

No

Copayment?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC -

BASE 12

What is your Inpatient

Hospital Psychiatric benefit

period?

Is authorization required?

Is a referral required for

Inpatient Psychiatric Hospital

Services?

Notes:

Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

Original Medicare

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a

supplemental benefit under

Part C?

Do you allow less than 3 day

inpatient hospital stay prior to

SNF admission?

Indicate the Number of

Hospital Days Required Prior to SNF Admission (0-2):

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicarecovered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee

obtains care?

Is there an enrollee

No

No

Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee

Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit

Original Medicare

period?

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

Services?

SECTION B: #3 CARDIAC AND PULMONARY

GUROSD EMR

REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac No 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 No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

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

Is authorization required? Yes Is a referral required for No

Cardiac and Pulmonary Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee No

Copayment?

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

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

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

No Is there an enrollee

Copayment?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT

COVERAGE - BASE 1

Does the plan provide Yes

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

Mandatory

Worldwide Emergency Coverage:

Select type of benefit for

Mandatory

Worldwide Urgent Coverage:

Is there a Maximum Plan

No

Benefit Coverage amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes: Coverage is managed through

reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

No

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee No

Copayment?

Yes

Is authorization required?
Is a referral required for

No

Partial Hospitalization?

Notes: Preauthorization required

through MCS Solutions, except for Emergency and

Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home

Yes

Health Services?

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide

Yes

Chiropractic Services as a supplemental benefit under

Part C?

Select enhanced benefit:

Routine Care

Select type of benefit for

Mandatory

Routine Care:

Is this benefit unlimited for

No, indicate number

Routine Care?

Indicate number of visits for

Routine Care:

Select Routine Care

Every year

periodicity:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

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Is there an enrollee

No

Deductible?

Is authorization required?

No

Is a referral required for

Yes

Chiropractic Services?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES -

BASE 2

Is authorization required?

Yes

Is a referral required for

No

Occupational Therapy

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES -

BASE 2

Is authorization required?

No

Is a referral required for

Yes

Physician Specialist Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Contrato Número

Is there an enrollee

No

Copayment?

SECTION B: #7E MENTAL HEALTH SPECIALTY

SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

No

Mental Health Specialty Services - Non-Physician?

Notes:

Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide

No

Podiatry Services as a supplemental benefit under

Part C?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

No

Is a referral required for

Yes

Podiatrist Services?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL

- BASE 2

Is authorization required?

No

Is a referral required for Other

Yes

Health Care Professional

Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

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Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

No

Psychiatric Services?

Notes:

Preauthorization required through MCS Solutions.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

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

Is authorization required?

Yes

Is a referral required for

No

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 Yes

services?

Select the Medicare-covered

benefits that may have

Services

Additional Telehealth Benefits

: 7d: Physician Specialist

available:

Services

: 7e1: Individual Sessions for Mental Health Specialty

: 7a: Primary Care Physician

Services

: 7h1: Individual Sessions for

Psychiatric Services : 14e2: Diabetes Self-Management Training

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

No





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

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES -

BASE 3

Is authorization required for No

Additional Telehealth

Services?

Is a referral required for No

Additional Telehealth

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #7K OPIOID TREATMENT PROGRAM

SERVICES - BASE 2

Is authorization required? No Is a referral required for No

Opioid Treatment Program

Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 2

Is there an enrollee No

Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

SERVICES - BASE 3

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB

Contrato Número m OU POS DE SALJO **SERVICES - BASE 4**

Is authorization required? Yes Yes

Is a referral required for Outpatient Diagnostic

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD

SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for

Yes

Outpatient

Diagnostic/Therapeutic

Radiological, and X-Ray

Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES -

BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required for

Yes

Medicare-covered Outpatient

Hospital Services?

Is authorization required for

No

Medicare-covered

Observation Services?

Is a referral required for

Medicare-covered Outpatient

Yes

Hospital Services?

Is a referral required for

No





Medicare-covered Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee

No

Deductible?

Is there an enrollee No

Copayment?

Is authorization required? Yes
Is a referral required for Yes

Ambulatory Surgical Center

Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 2

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE -

BASE 3

Is authorization required? No Is a referral required for No

Outpatient Substance Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

1

Does the plan provide Yes

Outpatient Blood Services as a supplemental benefit under

Part C?

Select enhanced benefit: Three (3) Pint Deductible

Waived

Select type of benefit for

Mandatory

Three (3) Pint Deductible

Waived:

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?



MR

No

Is there an enrollee

Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for No

Outpatient Blood Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for

Yes

non-emergency Medicare

services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Yes

Transportation Services as a supplemental benefit under

Part C?

Select enhanced benefit: Plan Approved Health-related

Location

Select type of benefit for Plan

Mandatory

Every year

One-way

Approved Health-related

Location:

Is this benefit unlimited for No

number of trips for Plan Approved Health-related

Location?

Indicate number of trips for 30

Plan Approved Health-related

Location:

Select Plan Approved Health-

related Location Trips

periodicity:

Select Type of Transportation

for Plan Approved Health-

related Location:

Coextrato Número

: Medical Transport

Select Mode of Transportation

for Plan Approved Health-

related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No No

Is a referral required for Transportation Services?

Notes:

Transportation to Plan-

Approved Location provided by contracted transportation

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred

Yes

vendors/manufacturers for Durable Medical Equipment

(DME)?

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 1

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

No

A-2



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Is there an enrollee No

Coinsurance?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 2

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES -

BASE 3

Is authorization required? Yes

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES -

BASE 2

Is there an enrollee No

Copayment?

Yes Do you limit Diabetic

Supplies and Services to those from specified manufacturers?

Is authorization required? Yes

Notes: Pre-authorization by PCP (for

corresponding services) is

managed through

Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee No

Coinsurance?

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

No Is authorization required? No Is a referral required for



Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide

Yes

Acupuncture as a

supplemental benefit under

Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for

Mandatory

Number of Treatments:

Is this benefit unlimited for

No

Number of Treatments?

Indicate limit for Number of

6

Treatments:

Indicate Number of

Every year

Treatments periodicity:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Acupuncture?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-

Yes

The-Counter (OTC) Items as a supplemental benefit under

Part C?

Select type of benefit for OTC

Mandatory

Items:

Is there a service-specific

Yes

Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage amount:

0.00

Select Maximum Plan Benefit

Every month

Coverage periodicity:

Does your Maximum Plan

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

Yes



we the

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

No

Are you offering Nicotine Replacement Therapy (NRT) No

as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Does this cover all of the OTC

No

list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

This benefit is combined with the SSBCI Benefit Card. The combined amount appears in

Section D.

For members that are not SSBCI-eligible, the monthly balance will only be available for allowed OTC Items.

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?

No

Is a referral required?

No

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

Does the plan provide the

No

Annual Physical Exam as a



supplemental benefit under

Part C?

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

Does the plan provide Other

Yes

Defined Supplemental Benefits as a benefit under

Part C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education : 14c2: Nutritional/Dietary

Benefit

: 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline)*

: 14c17: Alternative

Therapies*

: 14c18: Therapeutic

No, indicate number

Individual Sessions

: Physical Fitness

Massage*

Select type of benefit for

Health Education:

Mandatory

Mandatory

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

Fitness Benefit:

Mandatory

Mandatory

6

Indicate type of Fitness

Benefit offered (Select all that

apply):

Select type of benefit for

Remote Access Technologies (including Web/Phone-based

technologies and Nursing

Hotline):

Select the type of Remote

Access Technologies offered (Select all that apply):

: Web/Phone-based technologies

: Nursing Hotline

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for

Alternative Therapies?

No, indicate number



Indicate number of visits offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 3

Select type of benefit for

Mandatory

Therapeutic Massage:

Is this benefit unlimited? No Indicate limit for number of 6

sessions

Indicate the number of Every year

sessions periodicity:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 4

Is there a service-specific No

Maximum Plan Benefit Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 7

Is there a service-specific No

Maximum Enrollee Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 10

Is there an enrollee No

Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 12

Is there an enrollee No

Deductible?

Is there an enrollee No

Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL

BENEFITS - BASE 14

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

Defined Supplemental

Benefits?

Nutritional/Dietary Benefit Personal evaluation and diet

Notes: plan designed by licensed

dietitian according to patient's health needs, including exercise suggestions.

Fitness Benefit Notes:* Exercise and Nutrition

Education Interventions. Member has access to fitness classes to promote physical Contrato Número

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activity and a healthier

lifestyle.

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

Remote Access Technology

(Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement faceto-face visits with a boardcertified physician to treat the most common conditions,

such as allergies, flu, among

others.

Remote Access Technologies (Nursing Hotline) Notes:

Nursing Hotline.

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

Alternative Therapies Notes:* Foot reflexology is limited to

> six (6) visits per year and must be ordered by a physician or

medical professional.

Therapeutic Massage must be Therapeutic Massage Notes:

ordered by a physician or medical professional.

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

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

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

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Kidney Disease Education

Services?

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

Is there a service-specific

No

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

No

Coinsurance?



Is there an enrollee No

Deductible?

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

Is there an enrollee

No

Copayment?

Is authorization required for

r No

Medicare-covered Glaucoma

Screening?

Is authorization required for

No

Medicare-covered Diabetes

Self-Management Training?

Is authorization required for

No

No

Medicare-covered Barium

Enemas?

Is authorization required for

ii cu ioi

Medicare-covered Digital

Rectal Exams?

Is authorization required for

No

Medicare-covered EKG following Welcome Visit?

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

Is a referral required for any No

Services?

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

Is there a Maximum Enrollee No.

Out-of-Pocket Cost?

Is there an enrollee No

Coinsurance?

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

Is there an enrollee No

Copayment?

Is there an enrollee No

Deductible?

Is Authorization Required? Yes
Does the plan offer step Yes

therapy?

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D No

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 No

Preventive Dental Items as a

Costrato Número M

Yes

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: : Non-routine Services

> : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Select type of benefit for Non-

routine Services:

Mandatory

Is this benefit unlimited for

Non-routine Services?

Yes

Select type of benefit for

Diagnostic Services:

Mandatory

Is this benefit unlimited for

Diagnostic Services?

No, indicate number

Indicate number of visits for

Diagnostic Services:

1

Select the Diagnostic Services

periodicity:

Every six months

Select type of benefit for

Restorative Services:

Mandatory

Is this benefit unlimited for

Restorative Services?

Restorative Services:

No, indicate number

Indicate number of visits for

Select the Restorative Services

Every three years

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

1

Select type of benefit for

Mandatory

Endodontics:

Is this benefit unlimited for

Yes

Endodontics?

Select type of benefit for

Periodontics:

Is this benefit unlimited for

Periodontics?

Yes

Select type of benefit for

Extractions:

Mandatory

Mandatory

Is this benefit unlimited for

Yes

Extractions?



Select type of benefit for

Mandatory

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

Is this benefit unlimited for

Yes

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan

Plan-specified amount per

Benefit Coverage type:

period

Indicate Maximum Plan

1000.00

Benefit Coverage amount:

Select the Maximum Plan

Every year

Benefit Coverage periodicity:

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee

No

Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for

No

Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye

Yes

Exams as a supplemental

benefit under Part C?

Select enhanced benefit:

: Routine Eye Exams

Select type of benefit for

Mandatory

Routine Eye Exams:

Is this benefit unlimited for

No, indicate number

Routine Eye Exams?

Indicate number of exams for

1

Routine Eye Exams:

Every year

periodicity:

Select the Routine Eye Exams

Is there a service-specific Maximum Plan Benefit

No



Coverage amount?

Is there a service-specific Maximum Enrollee Out-ofNo

Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

No

Is a referral required for Eye

No

Exams?

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide

Yes

Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and

frames)

: Eyeglass lenses : Eyeglass frames

Select type of benefit for

Contact lenses:

Mandatory

Mandatory

Is this benefit unlimited for

Yes

Contact lenses?

Select type of benefit for

Eyeglasses (lenses and

frames):

Eyeglasses (lenses and

frames)?

Yes Is this benefit unlimited for

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for

Mandatory

Eyeglass lenses:

Is this benefit unlimited for

Yes

Eveglass lenses?

Select type of benefit for

Mandatory

Eyeglass frames:

Is this benefit unlimited for

Yes

Eyeglass frames?

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage type:

period



Yes

0.00

Do you offer a Combined Max

Plan Benefit Coverage Amount for all Eyewear?

Indicate Combined Maximum

Plan Benefit Coverage

Select the Combined

amount:

Every year

Maximum Plan Benefit Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

No

Is a referral required for

No

Eyewear? Notes:

Eyewear benefit maximum

amount includes repair of eyewear. This benefit amount is combined with a hearing aid

maximum amount.

Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing

Yes

Exams as a supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams

: Fitting/Evaluation for

Hearing Aid

Select type of benefit for

Routine Hearing Exams:

Mandatory

Is this benefit unlimited for

No, indicate number

Routine Hearing Exams?

1

Hearing Exams:

Select Routine Hearing Exams

Indicate number for Routine

Every year

periodicity:

Select type of benefit for

Mandatory



Fitting/Evaluation for Hearing

Is this benefit unlimited for Fitting/Evaluation for Hearing

No, indicate number

Aid?

Indicate number for

Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for

Every year

Hearing Aid periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific

No

1

Maximum Plan Benefit Coverage amount?

Is there an enrollee

No

Deductible?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing

Yes

Aids as a supplemental benefit

under Part C?

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for

Mandatory

Hearing Aids (all types):

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

No, indicate number

Indicate quantity for Hearing

2

Aids (all types):

Select Hearing Aids (all types)

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific

Yes

Maximum Plan Benefit Coverage amount?

Does the Maximum Plan

Both ears combined

Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum Plan

Plan-specified amount per



6/7/22, 3:56 PM

Benefit Coverage type:

period 0.00

Indicate Maximum Plan

Benefit Coverage amount: Indicate Maximum Plan

Every year

Benefit Coverage periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee

No

Copayment?

Is there an enrollee

No

Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

No

Is a referral required for

Yes

Hearing Aids?

Notes:

Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices.

This benefit is combined with the eyewear maximum

amount.

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

Does your plan include MA Uniformity Flexibility with

reductions in cost or additional benefits?

No

No

Do you offer Special Supplemental Benefits for the

Chronically III?

No

Are you offering a VBID Hospice Benefit?

Yes

Are you offering Part C

benefits under the VBID

Model? (VBID Part D

Rewards and Incentives

programs should be entered in

Section Rx)

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition or Socioeconomic Status

Value-Based Insurance Design : I attest that



Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose : Medicare Health Risk

one or more):

Assessment

WHP Mode of Engagement

: Telephonic : In-Person

(choose one or more):

: Web-Based

Does your organization offer

No

No

Part C Rewards or Incentives for beneficiaries for the offer

of WHP Services?

Does your organization offer

provider incentives for offering or engaging beneficiaries in WHP

activities?

Program Connectedness: : Provider/Patient portals

Please check the way that : Data Warehouses

advance care plans and/or advance directives are

connected from your program

to access points of care.

Expected Number of 2324

Beneficiaries to be Engaged

Annually:

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

Does your VBID/MA No

Uniformity Flexibility/SSBCI benefit offer Part C reductions

in cost?

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

Does your VBID/MA Yes

Uniformity Flexibility/SSBCI benefit offer additional Part C

henefits?

How many packages do your 1 Additional Benefits contain?

(1-15)

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

Is this package applicable to VBID

VBID or MA Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Targeting Methodology - : Socioeconomic Status

Please choose one or both:



Select LIS reduction level: : Dual-Eligible Status (for

territories)

Expected Number of Enrollees

to be Targeted:

Expected Number of Enrollees

to be engaged and receive

Model benefits:

2324

2324

SECTION B: #19B ADDITIONAL BENEFITS FOR

Is there a prerequisite for any additional benefits for this

No

VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

package?

Select all the Non-Medicarecovered additional benefits offered in this package: : 13i: Non-Primarily Health Related Benefits for the

Chronically Ill

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

DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from

No

the plan-level deductible?

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

Is there a package level No

maximum coverage amount?

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

Notes: The following SSBCI benefits

will be offered:

- SSBCI Card* w/monthly periodicity and rollover - Pest Control and General Supports for Living - Home Assistance Services

w/quarterly periodicity - Transportation for Non-

Medical Needs

The following general categories will be covered for the SSBCI Card:

1. Food, produce and prepared foods

2. General supports for daily living

3. Transportation to Non-

Medical needs 4. OTC, Hygiene, personal care, first aid, hurricane

preparedness items

5. Gasoline and auto repairs

6. Cleaning Products, Air

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Quality Equipment and Services, Pest Control, hardware / tools to support house maintenance, appliances

- 7. Social needs benefits
- 8. Services supporting self-direction
- 9. Copays and coinsurances for health services, supports for complementary therapies 10. Items for physical and mental exercise, cognitive functions

The following Chronic Conditions will be covered:

- 1. Chronic alcohol and other drugs dependence
- 2. Autoimmune disorders
- 3. Cancer
- 4. Cardiovascular disorders
- 5. Chronic heart failure
- 6. Dementia
- 7. Diabetes
- 8. End-stage liver disease
- 9. End-stage renal disease (ESRD)
- 10. Severe hematologic disorders
- 11. HIV/AIDS
- 12. Chronic lung disorders
- 13. Chronic and disabling mental health conditions
- 14. Neurologic disorders
- 15. Stroke
- 16. Crohn's Disease
- 17. Ulcerative Colitis
- 18. Anemia
- 19. Chronic Obstructive

Pulmonary Disease (COPD)

- 20. Moderate to Severe
- Autism
- 21. Severe Mental Retardation
- 22. Rheumatologic disease
- 23. Hx of cancer (Personal history of cancer)
- 24. Hypertension
- 25. Valvular heart disease
- 26. Cerebrovascular disease
- 27. Chronic viral hepatitis C
- 28. Chronic liver disease
- 29. Neurodegenerative disease
- 30. Malnutrition and Cachexia
- 31. Obesity





32. Chronic kidney disease33. Colostomy status34. Non-pressure chronic

ulcer

35. Others (as identified).

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

ILL - TYPE: PACKAGE #1

Select what type of benefit : Food and Produce your Non-Primarily Health : Pest Control

Related Benefits for the : Transportation for Non-

Chronically III includes: Medical Needs

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND

PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food

and Produce as a supplemental

benefit under Part C?

Select type of benefit for Food

Mandatory

and Produce:

Is there a service-specific

Maximum Plan Benefit Coverage amount?

Yes

Yes

Indicate Maximum Plan

0.00

No

Benefit Coverage amount:

Select Maximum Plan Benefit

Coverage periodicity:

Every month

Is there a service-specific

Maximum Enrollee Out-of-

Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for Food

No

and Produce?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: This benefit is combined with

OTC. The combined amount appears in Section D. Unused balances rollover to the next month. For members that are not SSBCI-eligible, the monthly balance will only be

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available for allowed OTC

Items.

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

Does the plan provide Pest

Control as a supplemental

Yes

benefit under Part C? Select type of benefit for Pest

Mandatory

Control:

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

No

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

No

Deductible?

Is there an enrollee

Copayment?

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

Control?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL -**BASE 3: PACKAGE #1**

Services listed in this category Notes:

> will be combined with those filed under SSBCI Category "General Supports for Living".

Member will choose up to Three (3) Services per quarter from the following options:

- Pest Control - Preventive home cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General Supports

for Living")

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 1: PACKAGE #1

Does the plan provide Transportation for Non-Medical Needs as a

Yes

supplemental benefit under Part C?

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Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-

approved Location:

Mandatory

Is this benefit unlimited for number of trips for Planapproved Location? No

Indicate number of trips for Plan-approved Location:

0

Select Plan-approved Location

Trips periodicity:

Every year

Select Type of Transportation for Non-Medical Needs for

One-way

Plan-approved Location: Select Mode of Transportation for Non-Medical Need for

: Medical Transport : Other, Describe

Plan-approved Location:

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 2: PACKAGE #1

Is there a service-specific

Maximum Plan Benefit Coverage amount?

No

No

Is there a service-specific Maximum Enrollee Out-of-

Pocket Cost?

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee

No

Copayment?

Is authorization required? No Is a referral required for No

Transportation for Non-

Medical Needs?

Notes:

Fleet includes 4-door sedans,

minivans, buses with hydraulic ramps.

The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the beneficiary qualifies for

SSBCI.

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



Yes

Does the plan provide General

Supports for Living as a supplemental benefit under

Part C?

Select type of benefit for

Mandatory

General Supports for Living:

Is there a service-specific

No

Maximum Plan Benefit Coverage amount?

Is there a service-specific

No

Maximum Enrollee Out-of-

Pocket Cost?

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

Is there an enrollee

No

Coinsurance?

Is there an enrollee

No

Deductible?

Is there an enrollee

No

Copayment?

Is authorization required?

No

Is a referral required for

No

General Supports for Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:

Home Assistance - Twelve

(12) visits per year (three per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance, Hairstyling, Basic Gardening)

and categories listed under

Pest Control.

SECTION C: V/T - GENERAL - US

Do you offer a US

No

Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan

No

Deductible?

SECTION D: MAX ENROLLEE COST LIMIT (IN-

NETWORK)

Is there an In-Network

Yes

Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum

Lower

Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory

Level?



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3400.00 Indicate In-Network

Maximum Enrollee Out-of-Pocket Cost Amount:

Select the benefits that apply : In-Network Medicareto the In-Network Maximum covered benefits

Enrollee Out-of-Pocket cost:

Does the In-Network Yes

Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered

plan services?

SECTION D: REDUCTIONS IN COST SHARING -**GENERAL**

Do you offer Reductions in No

Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined

Supplemental Benefits with uniform cost sharing?

Select the number of 2

Combined Supplemental Benefit packages you are

offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare : 17b1: Contact Lenses

covered benefits are included : 17b2: Eyeglasses (lenses and

in your Combined frames)

: 17b3: Eyeglass lenses Supplemental Benefit package: : 17b4: Eyeglass frames : 18b1: Hearing Aids (all

types)

What is your combined : Other

supplemental benefits mode of

delivery?

Other Description: Combined Eyewear and

Hearing Allowance

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit

amount?

Max Plan Benefit Amount: 800.00 Select Maximum Plan Benefit

Coverage Amount Periodicity:

Do you offer Combined Supplemental Benefits with a Yes

No

Every year

No



Contrato Número

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shared visit limit?

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare : 13b: Over-the-Counter

covered benefits are included (OTC) Items

in your Combined : 19b: Additional Benefits for

Supplemental Benefit VBID/UF/SSBCI

package:

What is your combined : Other

supplemental benefits mode of

delivery?

Other Description: Combined SSBCI Card/OTC

benefit

No

Yes

No

Yes

Every month

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must

select in advance?

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit

amount?

Max Plan Benefit Amount: 250.00

Select Maximum Plan Benefit

Coverage Amount Periodicity:

Do you offer Combined

Supplemental Benefits with a

shared visit limit?

SECTION D: NOTES

Notes: Non-SSBCI eligible members

will receive full card allowance in OTC.

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a

Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit: Defined Standard

Describe the components of your pharmacy network (select all that apply): Standard Mail-Order : Long-Term Care

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

SECTION RX: MEDICARE RX GENERAL 2

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 : Standard Retail Cost Sharing

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sharing Location/supply - 1 month Supply amount(s) that apply: : Standard Retail Cost Sharing - 2 month Supply : Standard Retail Cost Sharing - 3 month Supply Enter number of days for 30 Standard Retail Cost Sharing 1-month supply: Enter number of days for 60 Standard Retail Cost Sharing 2-month supply: 90 Enter number of days for Standard Retail Cost Sharing 3-month supply: Select all Out-of-Network : Out-of-Network Pharmacy -Pharmacy Location/supply one month supply amount(s) that apply: Enter number of days for Out-30 of-Network Pharmacy 1month supply: Select all Standard Mail-Order : Standard Mail-Order - 3-Cost Sharing Location/supply month supply amount(s) that apply: 90 Enter number of days for Standard Mail-Order Cost Sharing 3-month supply: Select the Long-Term Care : Long-Term Care Pharmacy -Pharmacy one month 1-month supply Location/supply amount(s) that apply: Enter number of days for 31 Long-Term Care Pharmacy 1month supply: Are all of the drugs on your No formulary available with an extended day supply? Are any of the drugs available Yes at an extended day supply limited to a 1-month supply



SECTION RX: VBID - GENERAL No

Are you offering Part D Benefits and/or Part D

Rewards and Incentives under

the VBID Model?

for the first fill?