MEDICARE PLATINO CONTRACT



APPENDIX C (1) (23)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT



DATA REPORT FOR Contract H4003, PLAN 017, SEGMENT 0

PBP Module: Requested By: rcqg

PLAN SYSTEM INFORMATION

06/01/2022 Last entry Date: PBP Software Version: 2023.01

Plan Ready for Upload Timestamp: 06/01/2022 10:16:47 AM SA Western Standard

Time

07/14/2022 01:53:12 PM SA Western Standard MA BPT Timestamp:

06/03/2022 02:46:42 PM SA Western Standard PD BPT Timestamp:

Time

07/15/2022 01:39:34 PM SA Western Standard Last Upload File Creation Timestamp:

Time

07/15/2022 #02983 Upload Status:

PLAN STATUS

Plan Ready for Upload Section A Status

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

Section B19 Status Completed Section C Status Completed

Section D Status Completed Section Mrx Status Completed

SECTION A: SECTION A-1

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

Service Area(s):

MMM HEALTHCARE, LLC Medicare y Mucho Mas www.mmmpr.com MMM Diamante Platino (HMO D-SNP) Local CCP

HMO Part A and Part B 40010 - Adjuntas, PR

40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR

40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR

40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR

40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR

40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR

40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR

40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR

40280 - Guayama, PR 40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR 40320 - Hatillo, PR

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

Service Area(s):

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

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40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR

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Service Area(s):	40750 - Villalba, PR 40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	017
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	(=0=) <=0 0.000
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current	(711)-



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Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Prospective Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Part D Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Part D Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

SECTION A: SECTION A-5

Is your organization filing a standard bid for No

Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for No

Section D of the PBP?

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

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

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

C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

obtains care?

Is there an enrollee Coinsurance?

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

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

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

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

period?

Do you charge cost sharing on the day of No



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discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

discharge?

No

Is authorization required? Is a referral required for Inpatient Psychiatric Yes No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

 \mathbb{C} ?

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Yes

Indicate the Number of Hospital Days Required

Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

No

which an enrollee obtains care? Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No

SECTION B: #2 SNF - BASE 10





What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C? Select enhanced benefit:

: Worldwide Emergency Coverage
: Worldwide Urgent Coverage
Mandatory

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

Yes

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No

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

500.00 Indicate Maximum Plan Benefit Coverage

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

\$75.00 Indicate Maximum Copayment amount for

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefit:

: Routine Care

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Select Routine Care periodicity:

Every year

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes

Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Occupational Therapy

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No







Is there an enrollee Copayment?

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No

Indicate number of Routine Foot Care visits:

6

Select the Routine Foot Care periodicity:

Every year

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Podiatrist Services?

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No Is there an enrollee Deductible?

No

Is there an enrollee Copayment? No

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

Is authorization required?

Yes





Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

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

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

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

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

Notes: ADDITIONAL TELEHEALTH SERVICES

No

Yes

No

No

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

: 7d: Physician Specialist Services

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

Is there a service-specific Maximum Enrollee No SMR



Out-of-Pocket Cost?

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

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

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

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

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Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Ambulatory Surgical

No

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Select enhanced benefit:

Mandatory

Yes

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Select Type of Transportation for Plan

One-way

Yes

Approved Health-related Location:

Select Mode of Transportation for Plan : Taxi

Approved Health-related Location: : Rideshare Services

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Transportation

No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

No

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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Yes



SECTION B: #13A ACUPUNCTURE - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 1

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

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

Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage 100.00 amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Care Manual?

Every three months

No

No

Yes

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

THE FOLLOWING CATEGORIES ARE COVERED:

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

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING

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SPECIFICALLY MONITOR BLOOD **PRESSURE** (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL **EVALUATION AND/OR** PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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

: Immediately following surgery or inpatient

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Yes

No

No

Mandatory

hospitilization

Select type of benefit for Meals:

Select the type of primarily health related meals benefit offered:

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

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

SECTION B: #13C MEAL BENEFIT - BASE 2

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

SECTION B: #13C MEAL BENEFIT - BASE 3



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POST DISCHARGE Notes:

2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

PER YEAR.

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

No

Yes

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? Yes Is a referral required? No

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

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

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

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

No, indicate number

Indicate setting for Nutritional/Dietary Benefit:

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

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Select type of benefit for Remote Access Technologies (including Web/Phone-based Both Sessions (Individual and Group)

Mandatory

9

6

Mandatory

: Physical Fitness

: Memory Fitness

Mandatory

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technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

: Nursing Hotline

Mandatory

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

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

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit : 14c8: Home and Bathroom Safety Devices and

Coverage amount (Select all that apply): Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

100.00

100.00

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

Every three months

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

Indicate Maximum Plan Benefit Coverage

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage

periodicity for Home and Bathroom Safety

Devices and Modifications:

Every three months

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

Indicate Maximum Plan Benefit Coverage

amount for Alternative Therapies:

100.00

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Alternative Therapies:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

No

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

Is there an enrollee Coinsurance? No

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

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

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

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No

No

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



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

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS

Fitness Benefit Notes:*



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

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Remote Access Technologies (Nursing Hotline)
Notes:



THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO

EMR



THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED, 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS. THE FOLLOWING ITEMS WILL BE COVERED:

Home and Bathroom Safety Devices and Modifications Notes:*

1) MEDICAL BATHMAT

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

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

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

Alternative Therapies Notes:*

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

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

THIS IS A COMBINED BENEFIT WITH A





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

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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Is there an enrollee Deductible?

Is Authorization Required?

Does the plan offer step therapy?

Yes

No

Yes

Does the benefit step from (select all that

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

1

Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

Select the Restorative Services periodicity:

Services:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

No, indicate number

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

1

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

5000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

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Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes
Is a referral required for Comprehensive Dental No
Services?

Restorative Services Notes:

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

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE

PROSTHODONTIC SERVICES:

DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES

AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.

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

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS.







SURGICAL PLACEMENT OF IMPLANT
BODY, ENDOSTEAL IMPLANT, COVERED
ONE PER TOOTH PER LIFE. ABUTMENT
SUPPORTED PORCELAIN (METAL
AND/OR HIGH NOBLE METAL),
ABUTMENT SUPPORTED
PORCELAIN/CERAMIC CROWN, IMPLANT
SUPPORTED PORCELAIN CROWN
(CERAMIC) COVERED. CROWNS ON
IMPLANTS ARE COVERED 1 PER TOOTH
EVERY 5 YEARS WITH APPROPRIATE
JUSTIFICATION. IMPLANT SERVICES
WILL ONLY BE COVERED WHEN
PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

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

SECTION B: #17A EYE EXAMS - BASE 1

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

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

SECTION B: #17A EYE EXAMS - BASE 2

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

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

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

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

No

No

No

No

1.0

No

Yes

No

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

Mandatory

Yes

Mandatory

Yes



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SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

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

type:

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

Indicate Combined Maximum Plan Benefit 1000.00

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

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

for Hearing Aid?

Indicate number for Fitting/Evaluation for 1

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible? No
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

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

Is a referral required for Hearing Exams? No

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SECTION B: #18B HEARING AIDS - BASE 1

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

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all

Mandatory

types):

Is this benefit unlimited for Hearing Aids (all

types)?

Yes

Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select enhanced benefits:

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

Plan-specified amount per period

combined?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage amount:

3000.00

amount

Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity

Elevibility with reductions in cost or additional

Flexibility with reductions in cost or additional

benefits?

No

Do you offer Special Supplemental Benefits for

No

the Chronically III?

Yes

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

Yes

Section Rx)

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

: Value-Based Design Flexibilities by Condition or Socioeconomic Status

: Medicare Advantage Rewards and Incentives Programs



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Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

Yes

Type of Part C Reward or Incentive: : Gift Card

: Item : Other

20.00

Reward or Incentive Notes: LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s)

Frequency of Reward or Incentive Eligibility:

Other Description:

Other, Describe

AVAILABLE TO REEDEEM INSTANTLY

OR ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT.

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

Expected Number of Beneficiaries to be

Engaged Annually:

5092

No

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

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

: Gift Card

: Item : Other

Part C Reward or Incentive Notes: LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

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Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other Description:

Eligibility Criteria:

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

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

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

INCENTIVES: APPLICABLE TO

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

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING

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

Caracana and American

(RECEIVING

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

Maximum Annual Part C Rewards and

Incentives Available:

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?

No

150.00

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

Yes

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benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

Select LIS reduction level:

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

73337

Expected Number of Enrollees to be engaged

73337

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

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

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

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

Is there a package level maximum coverage

Yes

amount?

145.00

Specify the maximum benefit amount:

Every month

Select the package level maximum coverage

periodicity:

Select the Non-Medicare-covered benefits that apply to the package level maximum coverage: : 13b: Over-the-Counter (OTO) Repus

: 13i1: Food and Produce

: 13i2: Meals (beyond limited basis)

: 13i3: Pest Control

: 13i6: Social Needs Benefit

: 13i10: General Supports for Living

:13i-O1: Other 1 Non-Primarily Health Related

Benefit

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

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: 14c17: Alternative Therapies

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

Notes:

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

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

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

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

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

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

Indicate Maximum Plan Benefit Coverage

145.00

amount:

Select Maximum Plan Benefit Coverage periodicity:

Every month

STRACTURES SOLVER OS OFFICE OF SOLVER OS OFFICE OS OFFICE OF SOLVER OS OFFICE OS OFFICE OF SOLVER OS OFFICE OS OFFIC

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

No

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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Nicotine Replacement Therapy (NRT)

Attestation:

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

OTC or formulary drugs.

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

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

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:

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

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS, THIS BENEFIT MAY REOUIRE

MEDICAL EVALUATION AND/OR

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

12) PERSONAL HYGIENE PRODUCTS



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ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

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

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Mandatory

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

145.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

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

Notes: MONTHLY ALLOWANCE.

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

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

Select type of benefit for Meals (beyond limited

basis):

Mandatory

Is the meal benefit unlimited? Yes Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Every month

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING PREPARED FOOD.

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

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

Yes

No

Select type of benefit for Pest Control: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

UNDER THIS CATEGORY WE WILL BE Notes:

COVERING ITEMS SUCH AS: CLEANING

PRODUCTS.

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

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

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No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

UNDER THIS CATEGORY WE WILL BE Notes:

> **COVERING ENTERTAINMENT** (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL

GROOMING SERVICES.

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

Yes

Yes

No

No

145.00

Does the plan provide General Supports for

Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

PACKAGE #1

Every month

Mandatory

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

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

Is a referral required for General Supports for

Living?

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

UNDER THIS CATEGORY WE WILL BE Notes:

> COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND

> > EMR

CLOTHING, HARDWARE ITEMS.

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

Select what Other type of benefit your Non-: Other 1

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Primarily Health Related Benefits for the : Other 2 Chronically Ill includes: : Other 3

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

Enter name of Service: PET CARE
Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

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

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS,

GROOMING ITEMS AND SERVICES.

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

Enter name of Service: PERSONAL CARE ITEMS

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 145.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No

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Is a referral required for Other 2 Services?

No

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

Notes:

UNDER THIS CATEGORY WE WILL BE **COVERING PERSONAL CARE ITEMS** SUCH AS: HAIR GROWTH AND ANTI-

AGE / SPOT CREAMS.

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

Enter name of Service:

ROADSIDE ASSISTANCE, IN-HOME

MINOR REPAIRS AND OTHER

Select type of benefit for Other 3:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

300.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES*

(UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS* 3. PEST CONTROL (1 PER QTR.)

4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER

PROVIDES THEM. (1 VISIT PER YR.) 5. TECHNOLOGY CONNECTIVITY

SERVICES (1 IN-PERSON VISIT AND



UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE \$145 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness : Memory Fitness

all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 4: PACKAGE #1**

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

: 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit

: 14c8: Home and Bathroom Safety Devices and

Coverage amount (Select all that apply):

Modifications : 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

145.00

Select Maximum Plan Benefit Coverage

Monthly

periodicity for Fitness Benefit:

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

BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices 145.00 EMR. and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Other, Describe

Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage

145.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

BASE 12: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Fitness Benefit Notes:*

ITEMS SUCH AS THE FOLLOWING WILL

BE COVERED:

1) PHYSICAL EXERCISE PEDALS

2) STRETCH STRAPS

3) PUZZLES FOR MEMORY FITNESS

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and

Modifications Notes:*

MONTHLY ALLOWANCE.

ITEMS SUCH AS THE FOLLOWING WILL BE COVERED:

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



EMR



ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL

MEDICINE ITEMS.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

5092

Expected Number of Enrollees to be engaged

1052

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

No

amount?

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

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

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

No

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

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

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

Notes: THE INTENTION IS TO UTILIZE A

> PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

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

HEALTH CARE PROFESSIONALS.

SECTION B: #19C VBID HOSPICE-BASE 1

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

5%

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

5

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

Yes

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

5%

5%

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

5 Indicate the maximum per day amount

SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance? Yes

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

5%

5%

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



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T. I'm a diamental and the second	E WHO		
Indicate the maximum per drug amount	5		
Is there an enrollee Copayment?	No		
Is there an enrollee Coinsurance?	Yes		
Indicate the Minimum Coinsurance percentage	5%		
for Medicare covered Benefits for a respite care			
day:	50 /		
Indicate the Maximum Coinsurance percentage	5%		
for Medicare covered Benefits for a respite care day:			
Indicate the maximum per day amount	5		
SECTION B: #19C VBID HOSPICE- BASE 3	S		
	NT.		
Are you offering hospice supplemental benefits?	No		
SECTION C: V/T - GENERAL - US			
Do you offer a US Visitor/Travel Program?	No		
SECTION D: PLAN DEDUCTIBLE (IN-NETW	VORK)		
Is there an In-Network Plan Deductible?	No		
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)			
Is there an In-Network Maximum Enrollee Out-	Yes		
of-Pocket Cost?			
Is your In-Network Maximum Enrollee Out-of-	Lower		
Pocket (MOOP) Cost at the Lower, Intermediate			
or Mandatory Level?			
Indicate In-Network Maximum Enrollee Out-of-	3250.00		
Pocket Cost Amount:			
Select the benefits that apply to the In-Network	: In-Network Medicare-covered benefits		
Maximum Enrollee Out-of-Pocket cost:	: In-Network Non-Medicare-covered benefits		
Does the In-Network Maximum Enrollee Out-	Yes		
of-Pocket Cost apply to all In-Network Medicare-covered plan services?			
Does the In-Network Maximum Enrollee Out-	Yes		
of-Pocket Cost apply to all In-Network Non-	1 05		
Medicare-covered plan services?			
1.11 11 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1			

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Select the number of Combined Supplemental

Benefit packages you are offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental

Benefit package:

2

Yes

No

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

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies



SMR

What is your combined supplemental benefits mode of delivery?

Other Description:

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: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

What is your combined supplemental benefits mode of delivery?

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:

: Other

MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.

No

Yes

100.00

Every three months

No

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

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

: 19b: Additional Benefits for VBID/UF/SSBCI

: Debit Card

No

Yes

145.00

Every month

No

COMBINED BENEFITS #1:

THE FOLLOWING CATEGORIES ARE

COVERED FOR OTC:

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

THAT ALLEVIATE SYMPTOMS

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



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

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

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

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

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:

1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

COMBINED BENEFITS #2:

Notes:



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MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS, SUCH AS.

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

Contrato Número

ROSDE

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):

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?

Yes

Defined Standard

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

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

No

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SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Standard Retail Cost Sharing - 1 month Supply
Standard Retail Cost Sharing - 3 month Supply

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30 Enter number of days for Standard Retail Cost Sharing 1-month supply: Enter number of days for Standard Retail Cost 90 Sharing 3-month supply: Select all Out-of-Network Pharmacy : Out-of-Network Pharmacy - one month supply Location/supply amount(s) that apply: Enter number of days for Out-of-Network 30 Pharmacy 1-month supply: Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 3-month supply Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order 90 Cost Sharing 3-month supply: Select the Long-Term Care Pharmacy one : Long-Term Care Pharmacy - 1-month supply month Location/supply amount(s) that apply: Enter number of days for Long-Term Care 31 Pharmacy 1-month supply: Are all of the drugs on your formulary available No with an extended day supply? Are any of the drugs available at an extended No 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 No Rewards and Incentives under the VBID Model?





PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT



DATA REPORT FOR Contract H4003, PLAN 047, SEGMENT 0

Module:

PBP

Requested By:

rcqg

PLAN SYSTEM INFORMATION

Last entry Date:

06/01/2022

PBP Software Version:

2023.01

Plan Ready for Upload Timestamp:

06/01/2022 10:16:23 AM SA Western Standard

Time

MA BPT Timestamp:

07/14/2022 01:55:14 PM SA Western Standard

Time

PD BPT Timestamp:

06/03/2022 02:50:08 PM SA Western Standard

Time

Last Upload File Creation Timestamp:

07/15/2022 01:39:34 PM SA Western Standard

Time

Upload Status:

07/15/2022 #02983

PLAN STATUS

Section A Status

Plan Ready for Upload

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

Completed
Completed
Completed

Section B3 Status
Section B4 Status
Section B5 Status
Section B6 Status
Section B7 Status
Section B8 Status
Section B9 Status
Section B10 Status

Completed
Completed
Completed
Completed
Completed

Section B8 Status
Section B10 Status
Section B10 Status
Section B12 Status
Section B13 Status
Section B14 Status
Section B15 Status

Completed
Completed
Completed
Completed
Completed

Completed Completed Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed Section C Status Completed Completed Section D Status Section Mrx Status Completed

Contrato Número 3 0 17 / Contrato Número 3 0 1

SECTION A: SECTION A-1

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

Service Area(s):

Service Area(s):

Service Area(s):

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

40250 - Dorado, PR

40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR 40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR





PBP Data Report

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

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

40730 - Vega Baja, PR 40740 - Vieques, PR



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	40750 - Villalba, PR	JCA
Service Area(s):	40760 - Yabucoa, PR	10
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4003	
Plan ID:	047	
Segment ID:	0	
Contract Period:	2023	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No	
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		
Participating Pharmacy Website Address:	www.mmmpr.com	
Formulary Website Address:	www.mmmpr.com	
Physician Website Address:	www.mmmpr.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471	E .
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	WOOD CONTROL WINTERSO 3 O D T & S
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	W Medo Wires
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	141
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-4	(866)333-5471	SEGUROS OF
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396	(,,,)
Customer Service Contact TTY for Current	(711)-	EMR

Medicare	Danati	OLOVIOO!
VICULIANC	DEHELL	LIMITES
TITOGLOGIO	Deller	CIGILION.

Customer Service Contact Local TTY for (711)-

Current Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Prospective Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Part D Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Part D Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

SECTION A: SECTION A-5

Is your organization filing a standard bid for No

Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for No

Section D of the PBP?

Do any of your outpatient services have tiered No

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

in Section B of the PBP software)

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

Does the plan provide Inpatient Hospital-Acute No

Services as a supplemental benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

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

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

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

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

period?

Do you charge cost sharing on the day of No

WHO .





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discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Psychiatric No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

C?

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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No

Yes

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Per Admission or Per Stay

Do you charge cost sharing on the day of

What is your SNF benefit period?

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Mandatory

Coverage:

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

Yes

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Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

500.00

No

Indicate Maximum Plan Benefit Coverage amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

500.00

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

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Copayment?

Yes

Select which Worldwide Services have a

: Worldwide Emergency Coverage: Worldwide Urgent Coverage

Copayment (Select all that apply):

Worldwide Orgent Co

Indicate Minimum Copayment amount for

Worldwide Emergency Coverage:

\$75.00

\$75.00

Indicate Maximum Copayment amount for

LOI

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

\$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Is there an enrollee Coinsurance?

No

Out-of-Pocket Cost?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services?

No



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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

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Is there an enrollee Copayment?

No

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

Is authorization required?

No Yes

Is a referral required for Physician Specialist

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Select enhanced benefits:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

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Is a referral required for Other Health Care

Yes

No

Yes

No

No

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Psychiatric Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Additional Telehealth?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

Notes: ADDITIONAL TELEHEALTH SERVICES

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

: 7d: Physician Specialist Services

CLINICS.

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

Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

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

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

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

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

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
No
Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

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Is a referral required for Medicare-covered No Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

of



Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Select enhanced benefit:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Yes

Select Type of Transportation for Plan

One-way

Approved Health-related Location:

Select Mode of Transportation for Plan

: Taxi

Approved Health-related Location: : Rideshare Services

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No Yes

Is authorization required?

Is a referral required for Transportation

Services?

about:blank

No

SECTION B: #11A DME - BASE 1

Is there an enrollee Coinsurance?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Yes

Indicate Minimum Coinsurance percentage for

20%

Medicare-covered Benefits:

20%

Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

No



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No

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

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

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 20%

Medicare-covered Prosthetic Devices:

20% Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

20%

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? Yes

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

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

Select enhanced benefit:

: Number of Treatments

ROS

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Yes

Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Acupuncture?	Yes
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	100.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	, 0
Is there an enrollee Coinsurance?	No arción de
Is there an enrollee Deductible?	No STR
Is there an enrollee Copayment?	No N
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Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

No

NA

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE
- (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Yes



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Select type of benefit for Meals:

Select the type of primarily health related meals

benefit offered:

: Immediately following surgery or inpatient

hospitilization

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

SECTION B: #13C MEAL BENEFIT - BASE 2

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

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes: POST DISCHARGE

> 2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

PER YEAR.

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? Yes Is a referral required? No

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

Does the plan provide the Annual Physical No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

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

Hotline)*

Yes

: 14c8: Home and Bathroom Safety Devices and

SMR

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

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Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

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

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for 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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

6

Both Sessions (Individual and Group)

Mandatory

9

: Physical Fitness

No, indicate number

: Memory Fitness

Mandatory

: Nursing Hotline

Mandatory

Mandatory

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

Select type of benefit for Alternative Therapies:

Is this benefit unlimited for Alternative

Therapies?

Indicate number of visits offered for Alternative

Therapies:

No, indicate number

Yes

12

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply):

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and Modifications

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: 14c17: Alternative Therapies

100.00

100.00

Every three months

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

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

Indicate Maximum Plan Benefit Coverage

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Devices and Modifications:

Every three months

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Indicate Maximum Plan Benefit Coverage

100.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Alternative Therapies:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

STRATEGIES, EVALUATE THE RESULTS

AND CREATE FUTURE

GOALS.INTERVENTIONS MIGHT

INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES

NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL



Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

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

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

Fitness Benefit Notes:*



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ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

Home and Bathroom Safety Devices and Modifications Notes:*



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

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND



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BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Alternative Therapies Notes:*

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

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

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

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BAS

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

Is authorization required?

Is a referral required for Kidney Disease

Yes

Education Services?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Glaucoma Screening?

Is authorization required for Medicare-covered

Yes

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Yes

Yes

No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Yes

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

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

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

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

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Yes

Surgery, Other Services

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative No, indicate number

Services?

Indicate number of visits for Restorative 1

Services:

Select the Restorative Services periodicity: Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, No, indicate number

Other Oral/Maxillofacial Surgery, Other

Mandatory

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Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

amount:

1500.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes
Is a referral required for Comprehensive Dental No

Services?

Restorative Services Notes: CORE BUILDUP AND PIN RETENTION PER

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

AUTHORIZATION.

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

PROSTHODONTIC SERVICES:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE,

COVERED EVERY 5 YEARS. DENTURE

REPAIR SERVICES, INCLUDING

SERVICES RELATED TO THE REPAIR OF

EXISTING COMPLETE OR PARTIAL

DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES

AND/OR FLEXIBLE BASE ARE NOT

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COVERED IN COMPLETE OR FULL DENTURES.

WB.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.

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

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS. SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH **EVERY 5 YEARS WITH APPROPRIATE** JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

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

SECTION B: #17A EYE EXAMS - BASE 1

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

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

SECTION B: #17A EYE EXAMS - BASE 2

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

No

No

No

No



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Is there an enrollee Deductible? No **SECTION B: #17A EYE EXAMS - BASE 3** Is authorization required? Yes Is a referral required for Eye Exams? No **SECTION B: #17B EYEWEAR - BASE 1** Does the plan provide Eyewear as a Yes supplemental benefit under Part C? : Contact lenses Select enhanced benefits: : Eyeglasses (lenses and frames) Mandatory Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes Select type of benefit for Eyeglasses (lenses and Mandatory frames): Is this benefit unlimited for Eyeglasses (lenses Yes and frames)? SECTION B: #17B EYEWEAR - BASE 3 Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Plan-specified amount per period Select the Maximum Plan Benefit Coverage type: Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 450.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #17B EYEWEAR - BASE 5** Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #17B EYEWEAR - BASE 6** Is authorization required? No Is a referral required for Eyewear? No **SECTION B: #18A HEARING EXAMS - BASE 1** Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? : Fitting/Evaluation for Hearing Aid Select enhanced benefits: Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid:

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No, indicate number

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Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

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Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** Is there a service-specific Maximum Plan No Benefit Coverage amount? No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3** Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? Select enhanced benefits: : Hearing Aids (all types) Select type of benefit for Hearing Aids (all Mandatory types): Is this benefit unlimited for Hearing Aids (all Yes types)? **SECTION B: #18B HEARING AIDS - BASE 2** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined Amount apply per ear or for both ears combined? Select the Maximum Plan Benefit Coverage Plan-specified amount per period Indicate Maximum Plan Benefit Coverage 500.00 Indicate Maximum Plan Benefit Coverage Every two years periodicity: **SECTION B: #18B HEARING AIDS - BASE 3** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18B HEARING AIDS - BASE 4** Is there an enrollee Copayment? No

Is there an enrollee Deductible?

Is authorization required?

SECTION B: #18B HEARING AIDS - BASE 5







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No

Yes

Is a referral required for Hearing Aids?

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

Does your plan include MA Uniformity

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

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

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

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

No

No

No

: I attest that Value-Based Insurance Design Attestation

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

: Gift Card Type of Part C Reward or Incentive:

: Item : Other

Yes

LIMITED PURPOSE CARD. USAGE WILL Reward or Incentive Notes:

> BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

20.00 Part C Reward or Incentive amount(s)

Frequency of Reward or Incentive Eligibility:

Other, Describe

AVAILABLE TO REEDEEM INSTANTLY

OR ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT.

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Other Description:

Program Connectedness: Please check the way

that advance care plans and/or advance

: Electronic Health Records/Electronic Medical

Records

No

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directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Provider/Patient portals

1310

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

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

: Gift Card

1

: Item : Other

Part C Reward or Incentive Notes: LIMITED PURPOSE CARD, USAGE WILL

BE RESTRICTED TO CERTAIN

CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

130.00 Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other, Describe Other Description:

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

Eligibility Criteria: BENEFICIARIES WITH A QUALIFYING

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

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

INCENTIVES: APPLICABLE TO

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

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING

HEALTH CARE STAGES WILL BE **EXCLUDED: ESRD (RECEIVING**

DIALYSIS), ALZHEIMER'S (SEVERE OR

SMR

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LATE STAGE), ACTIVE CANCER

(RECEIVING

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

Maximum Annual Part C Rewards and

Incentives Available:

150.00

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

No

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

1310

Expected Number of Enrollees to be engaged

271

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Is there a package level maximum coverage

No

amount?

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

Notes: NEW AND INNOVATIVE TECHNOLOGIES

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

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

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

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

Notes: THE INTENTION IS TO UTILIZE A

PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

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

HEALTH CARE PROFESSIONALS.

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

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

VBID

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

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 18873

Expected Number of Enrollees to be engaged 1887

and receive Model benefits:

Select LIS reduction level:

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

for the Chronically III (Other)

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

Are any benefits exempt from the plan-level

deductible?

No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

No

amount?

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

Notes:

ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER

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

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

Chronically Ill includes:

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

Enter name of Service:

ROADSIDE ASSISTANCE, IN-HOME

MINOR REPAIRS AND OTHER

Select type of benefit for Other 1:

Mandatory

Other, Describe

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

300.00

No

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

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Other 1 Services? No

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

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES*

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(UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS*

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Yes

3. PEST CONTROL (1 PER QTR.)
4. ANTI-FALL PREVENTIVE MEASURES
VISIT (INCLUDES AN EVALUATION OF
THE HOME AND INSTALLATION OF LED
LIGHTING, TRACTION / ANTI-SLIP TAPE.
GRIP AND SAFETY BARS COULD ALSO
BE INSTALLED IF THE MEMBER
PROVIDES THEM. (1 VISIT PER YR.)
5. TECHNOLOGY CONNECTIVITY
SERVICES (1 IN-PERSON VISIT AND
UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

SECTION B: #19C VBID HOSPICE-BASE 1

Is there an enrollee Coinsurance?

day:

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

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Yes

Yes

1

5% Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day: 5 Indicate the maximum per day amount SECTION B: #19C VBID HOSPICE- BASE 3 Are you offering hospice supplemental benefits? No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK) Is there an In-Network Plan Deductible? No

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

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Lower Pocket (MOOP) Cost at the Lower, Intermediate

or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-3250.00

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Non-Medicare-covered benefits Does the In-Network Maximum Enrollee Out-Yes

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

Does the In-Network Maximum Enrollee Out-

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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL Yes

Do you offer Combined 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 in your Combined Supplemental

Benefit package:

What is your combined supplemental benefits mode of delivery?

Other Description:

Is the enrollee limited to one or more of the

: Other

MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE

: 14c8: Home and Bathroom Safety Devices and

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

: 14c4: Fitness Benefit

Modifications

: In-Network Medicare-covered benefits

ITEMS FROM A CATALOG.

: 14c17: Alternative Therapies

No



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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:



100.00

Every three months

No



- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT
- DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

SMR

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

THE FOLLOWING ITEMS WILL BE



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> **COVERED FOR ALTERNATIVE** THERAPIES:

1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE **COVERED FOR FITNESS BENEFIT:**

1) PHYSICAL EXERCISE PEDALS

2) STRETCH STRAPS

3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND **BATHROOM SAFETY DEVICES AND** MODIFICATIONS AND FITNESS BENEFIT.

Contrato Número

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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):

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?

No

Yes

Defined Standard

: Standard Retail

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

CFR 423.154.

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost Sharing 1-month supply:

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

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

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

: Standard Retail Cost Sharing - 1 month Supply

: Standard Retail Cost Sharing - 3 month Supply

30

: Sponsor attests that it will comply with 42

90

30

: Out-of-Network Pharmacy - one month supply

: Standard Mail-Order - 3-month supply

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Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order 90 Cost Sharing 3-month supply: Select the Long-Term Care Pharmacy one : Long-Term Care Pharmacy - 1-month supply month Location/supply amount(s) that apply: Enter number of days for Long-Term Care 31 Pharmacy 1-month supply: Are all of the drugs on your formulary available No with an extended day supply? Are any of the drugs available at an extended No day supply limited to a 1-month supply for the first fill? **SECTION RX: VBID - GENERAL** Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID No

Model?





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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 049, SEGMENT 0

Module: **PBP**

Requested By: rcqg

PLAN SYSTEM INFORMATION

Last entry Date: 06/01/2022 PBP Software Version: 2023.01

Plan Ready for Upload Timestamp: 06/01/2022 02:24:43 PM SA Western Standard

Time

07/14/2022 01:56:28 PM SA Western Standard MA BPT Timestamp:

Time

PD BPT Timestamp: 07/15/2022 10:29:30 AM SA Western Standard

07/15/2022 01:39:34 PM SA Western Standard Last Upload File Creation Timestamp:

Time

07/15/2022 #02983 **Upload Status:**

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed

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

Section B13 Status Completed Section B14 Status Completed Section B15 Status

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

Section B19 Status Completed Section C Status Completed Section D Status Completed

Section Mrx Status

SECTION A: SECTION A-1



SMR Completed

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Organization Legal Name:

Organization Marketing Name:

Organization Web Site: Plan Name:

Organization Type:

Plan Type:

Tian Type.

Enrollee Type: Service Area(s):

Service Area(s):

Service Area(s):

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MMM HEALTHCARE, LLC

Medicare y Mucho Mas

www.mmmpr.com

MMM Grande Platino (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR 40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



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Service Area(s):
Service Area(s):
0

Service Area(s):

Service Area(s):

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





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40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR

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	40750 - Villalba, PR	710
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4003	
Plan ID:	049	
Segment ID:	0	
Contract Period:	2023	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No	
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		
Participating Pharmacy Website Address:	www.mmmpr.com	
Formulary Website Address:	www.mmmpr.com	
Physician Website Address:	www.mmmpr.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	STRACION OF
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	A Contrato Número
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	(a)
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471	UROSO
SECTION A: SECTION A-4		(,,, 0
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396	ZMK
	ZP1.13	

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Customer Service Contact TTY for Current

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Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Prospective Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Part D Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Part D Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

SECTION A: SECTION A-5

Is your organization filing a standard bid for No

Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for No

Section D of the PBP?

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

in Section B of the PBP software)

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

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

C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

obtains care?

Is there an enrollee Coinsurance?

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

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

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

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

period?

Do you charge cost sharing on the day of No



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No

Yes

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital- No

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes

Is a referral required for Inpatient Psychiatric No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

No

C?

Do you allow less than 3 day inpatient hospital

stay prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

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

Yes

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No

No

who

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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





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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care

Yes

Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

Every year

6

Select Routine Care periodicity:

Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount?

750.00

Select enhanced benefit:

Indicate Maximum Plan Benefit Coverage

amount:

Every year

Select Maximum Plan Benefit Coverage

periodicity:

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

No Is there an enrollee Copayment?

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care

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

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

Every year Select the Routine Foot Care periodicity:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

Is authorization required? Yes

Yes Is a referral required for Podiatrist Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required?





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Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Psychiatric Services? Yes

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

Is there a service-specific Maximum Enrollee

E 1 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit

Yes

for Part B services?

Select the Medicare-covered benefits that may

: 7d: Physician Specialist Services

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

No

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required for Additional

No

Telehealth Services?

Is a referral required for Additional Telehealth

No

Services? Notes:

ADDITIONAL TELEHEALTH SERVICES

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS

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

Is there a service-specific Maximum Enrollee

No

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Out-of-Pocket Cost?

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

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

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

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

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Is a referral required for Medicare-covered No **Outpatient Hospital Services?**

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

Is authorization required? Yes Is a referral required for Ambulatory Surgical No

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No No

Is there an enrollee Copayment?

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

Is authorization required? Yes

Is a referral required for Outpatient Substance Yes

Abuse?

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

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2



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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

Select enhanced benefit:

No

12

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

Approved Health-related Location:

One-way

Select Mode of Transportation for Plan

Approved Health-related Location:

: Rideshare Services

: Bus/Subway

: Van

: Taxi

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance?

0% Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for

20%

No

Medicare-covered Benefits:

Is there an enrollee Deductible?



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No

10%

10%

Jeb

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Bed 5%, DME Power Wheelchair 20%, All

other DME 0%

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

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

a Coinsurance (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for 10%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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Is authorization required?

Yes

Is a referral required for Dialysis Services?

No

SECTION B: #13A ACUPUNCTURE - BASE 1

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

No

SECTION B: #13B OTC ITEMS - BASE 1

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

Items as a supplemental benefit under Part C?

Yes

Select type of benefit for OTC Items:

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage amount:

50.00

Select Maximum Plan Benefit Coverage

periodicity:

Every three months

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

unused?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

Nicotine Replacement Therapy (NRT)

Attestation:

Yes

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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

No No No

No

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THE FOLLOWING CATEGORIES ARE COVERED:

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

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING

SPECIFICALLY MONITOR BLOOD

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NA

PRESSURE

(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL **EVALUATION AND/OR** PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING. BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

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

SECTION B: #13C MEAL BENEFIT - BASE 1

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

Select type of benefit for Meals:

Select the type of primarily health related meals benefit offered:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Is a referral required for the Meal Benefit?

Yes

Mandatory

: Immediately following surgery or inpatient hospitilization

No

No

Yes



Notes:

POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

PER YEAR.

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

Is a referral required?

Yes No

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

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

No

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

C?

Yes

: 14c1: Health Education

14c2: Nutritional/Dietary Benefit

14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

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

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

: 14c21: In-Home Support Services*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

Indicate setting for Nutritional/Dietary Benefit:

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

Indicate number of visits offered in addition to

Medicare:

Both Sessions (Individual and Group)

Mandatory

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Select type of benefit for Remote Access

9

6

Mandatory

: Physical Fitness

: Memory Fitness

Mandatory

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Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

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

Select type of benefit for In-Home Support Mandatory

Services:

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

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit : 14c8: Home and Bathroom Safety Devices and

Coverage amount (Select all that apply): Modifications

: 14c17: Alternative Therapies

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Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

50.00

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

Every three months

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

Indicate Maximum Plan Benefit Coverage 50.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage Every three months

periodicity for Home and Bathroom Safety

Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage 50.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage Every three months

periodicity for Alternative Therapies:

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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

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

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

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

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM **DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED** ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

STRATEGIES, EVALUATE THE RESULTS

AND CREATE FUTURE

GOALS.INTERVENTIONS MIGHT

INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO

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

AS PART OF THE EDUCATIONAL

INTERVENTIONS.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:



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

Fitness Benefit Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Remote Access Technologies (Nursing Hotline) Notes:



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

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

Home and Bathroom Safety Devices and Modifications Notes:*

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

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

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

Alternative Therapies Notes:*



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

THE MAXIMUM BENEFIT COVERAGE

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> AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

In-Home Support Services Notes:* FLEXIBLE SUPPLEMENTAL BENEFITS: IF

> MEMBER SELECTS THE IN-HOME SUPPORT SERVICES BENEFIT, THEY WILL BE ELIGIBLE FOR UP TO 4-HOUR IN-HOME CARE VISITS (UP TO 12 HRS. PER QUARTER, FOR A MAXIMUM

> AMOUNT OF 48 HRS. TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY

LIVING, PA MAY APPLY.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance? SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

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

Education Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

No

Is there an enrollee Copayment?

Is authorization required for Medicare-covered

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

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Yes

No

No

No

Yes

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

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

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance? No

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

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

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

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

: Restorative Services Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

1 Indicate number of visits for Restorative

Services:

Other, Describe Select the Restorative Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

No, indicate number

Services?

Indicate number of visits for Prosthodontics, 1

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Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

ype:

Indicate Maximum Plan Benefit Coverage

2000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes
Is a referral required for Comprehensive Dental No

Services?

Restorative Services Notes: CORE BUILDUP AND PIN RETENTION PER

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

AUTHORIZATION.

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

PROSTHODONTIC SERVICES:

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

REPAIR SERVICES, INCLUDING

SERVICES RELATED TO THE REPAIR OF

EXISTING COMPLETE OR PARTIAL

DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES

AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL

DENTURES.

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FIXED DENTURES: UP TO 4 UNITS PER YEAR.

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

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS. SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH **EVERY 5 YEARS WITH APPROPRIATE** JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

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

No

No

No

No

No

SECTION B: #17A EYE EXAMS - BASE 1

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

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

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?
Is there an enrollee Copayment?
Is there an enrollee Deductible?
SECTION B: #17A EYE EXAMS - BASE 3



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Yes

Yes

Yes

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

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes Mandatory

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

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

SECTION B: #17B EYEWEAR - BASE 3

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

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

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

Indicate Combined Maximum Plan Benefit 500.00 Coverage amount:

Select the Combined Maximum Plan Benefit Every year Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

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

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1

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

Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for Hearing Aid:

1

No, indicate number

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Select Fitting/Evaluation for Hearing Aid

Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there an enrollee Deductible?

No

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all

types):

Mandatory

Is this benefit unlimited for Hearing Aids (all

types)?

Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

Both ears combined

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

amount:

1000.00

Indicate Maximum Plan Benefit Coverage

Every three years

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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



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

benefits?

Do you offer Special Supplemental Benefits for

the Chronically III?

No

No

Are you offering a VBID Hospice Benefit?

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

Yes Yes

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

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

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

WHP Services?

Yes

Type of Part C Reward or Incentive:

: Gift Card : Item : Other

Reward or Incentive Notes:

LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s) 20.00

Frequency of Reward or Incentive Eligibility:

Other Description:

Other, Describe

AVAILABLE TO REEDEEM INSTANTLY

OR ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT.

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

No

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

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Expected Number of Beneficiaries to be

Engaged Annually:

213

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

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

: Gift Card

: Item : Other

130.00

Part C Reward or Incentive Notes:

LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other Description:

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

Eligibility Criteria:

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

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

INCENTIVES: APPLICABLE TO

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

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT

ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE

EXCLUDED: ESRD (RECEIVING

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

(RECEIVING



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

Maximum Annual Part C Rewards and

Incentives Available:

150.00

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

Does your VBID/MA Uniformity

Yes

1

Flexibility/SSBCI benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

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

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

Is this package applicable to VBID, MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

3073

Expected Number of Enrollees to be engaged

3073

and receive Model benefits:

Select LIS reduction level:

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

Is there a prerequisite for reduction of cost

No

sharing for this package?

Does the plan reduce cost sharing to \$0 for all

covered benefits, up to a maximum aggregate

amount?

No

Select the benefits that apply to reduced cost

sharing:

: Medicare-covered benefits

Select the Medicare-covered benefits that will

receive reduced cost sharing:

: 11a: Durable Medical Equipment (DM : 11b1: Prosthetic Devices

: 11b2: Medical Supplies

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

Are any benefits exempt from the plan-level

No

deductible?

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

Do you offer reduced Coinsurance?

Yes

Select the types of benefits that apply to the

: Medicare-covered benefits

FMR

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coinsurance cost sharing:

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

receive reduced coinsurance: : 11b1: Prosthetic Devices

: 11b2: Medical Supplies

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

Indicate Minimum Coinsurance Percentage for 0%

Durable Medical Equipment (DME)

Indicate Maximum Coinsurance Percentage for 0%

Durable Medical Equipment (DME)

0% Indicate Minimum Coinsurance Percentage for

Prosthetic Devices

Indicate Maximum Coinsurance Percentage for

Prosthetic Devices

Indicate Minimum Coinsurance Percentage for

Medical Supplies

Indicate Maximum Coinsurance Percentage for

Medical Supplies

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

0%

0%

0%

No

No

Yes

Do you offer a reduced deductible amount?

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

Do you offer reduced Copayment?

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

(MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a maximum aggregate amount of

reduced cost sharing?

reduced cost sharing:

Specify the maximum aggregate amount of 180.00

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

MONTHLY ALLOWANCE IN THE FORM Notes:

> OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND

19B.

Yes

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

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off

benefits?

How many packages do your Additional

3

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

Select LIS reduction level:

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

3073

Expected Number of Enrollees to be engaged

3073

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

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

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

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

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level deductible?

No

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

Is there a package level maximum coverage amount?

Yes

amount?

180.00

Specify the maximum benefit amount: Select the package level maximum coverage

Every month

periodicity:

·

Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:

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

: 13i1: Food and Produce

: 13i2: Meals (beyond limited basis)

: 13i3: Pest Control

: 13i6: Social Needs Benefit

: 13i10: General Supports for Living

: 13i-O1: Other 1 Non-Primarily Health Related

Benefit

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications



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who

: 14c17: Alternative Therapies

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

Notes:

EMBEDDED SUPPLEMENTAL BENEFITS: MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B, SUCH AS:

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

FLEXIBLE SUPPLEMENTAL BENEFITS: ADDITIONAL MONTHLY ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

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

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

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

Select type of benefit for OTC Items:

Yes

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

180.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

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

unused?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Nicotine Replacement Therapy (NRT)

Attestation:

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

OTC or formulary drugs.

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

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

Care Manual?

No

No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:

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

THAT ALLEVIATE SYMPTOMS

- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING

SPECIFICALLY MONITOR BLOOD

PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING

MONITORING OF BLOOD PRESSURE, THE

PLAN WILL PROVIDE ONE (1) BLOOD

YEARS. THIS BENEFIT MAY REQUIRED MEDICAL EVALUATION

MEDICAL EVALUATION AND/OR

PREAUTHORIZATION.

- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFOR

MR

10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) 12) PERSONAL HYGIENE PRODUCTS

ITEM OUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

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 Related Benefits for the Chronically Ill

includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

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

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

180.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

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

Notes:

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

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

Select type of benefit for Meals (beyond limited

basis):

Is the meal benefit unlimited?

Yes

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

180.00

amount:

Select Maximum Plan Benefit Coverage

Every month

Mandatory

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for the Meals (beyond

No

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE

COVERING PREPARED FOOD.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

Does the plan provide Pest Control as a

Yes

supplemental benefit under Part C?

Mandatory

Select type of benefit for Pest Control:

Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount?

180.00

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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



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

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING

PRODUCTS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Select type of benefit for Social Needs Benefit:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

180.00

amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Social Needs Benefit?

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE

COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL

GROOMING SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

Does the plan provide General Supports for

Yes

Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Mandatory

Living:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Indicate Maximum Plan Benefit Coverage

180.00

amount:

SMR

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Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for

Living?

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

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND

CLOTHING, HARDWARE ITEMS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

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

Select what Other type of benefit your NonPrimarily Health Related Benefits for the
Chronically Ill includes:
: Other 2
: Other 3

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

Yes

Enter name of Service: PET CARE
Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 180.00

amount:

Select Maximum Plan Benefit Coverage

beleet waximum r lan beliefft coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No



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Is a referral required for Other 1 Services?

No

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

Notes:

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

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

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

Enter name of Service:

PERSONAL CARE ITEMS

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

180.00

amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Other 2 Services?

No

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

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTIAGE / SPOT CREAMS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

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

BENEFIT - BASE 1: PACKAGE #1

ROADSIDE ASSISTANCE, IN-HOM

MINOR REPAIRS AND OTHER

Select type of benefit for Other 3:

Enter name of Service:

Mandatory

Is there a service-specific Maximum Plan

Yes

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Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

300.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 3 Services?

No

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

Notes:

EMBEDDED SUPPLEMENTAL BENEFIT: MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES*
(UP TO ONE WINDSHIELD
REPLACEMENT AND BATTERY
REPLACEMENT PER YEAR)
2. IN-HOME MINOR REPAIRS*
3. PEST CONTROL (1 PER QTR.)

4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.) 5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE \$180 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT:

EMR

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ADDITIONAL ALLOWANCE FOR DEBIT

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

CARD OF \$50 PER MONTH.

Select type of benefit for Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness

all that apply):

: Memory Fitness

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 4: PACKAGE #1**

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Yes

Select which Other Defined Supplemental

: 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit

: 14c8: Home and Bathroom Safety Devices and

SMR

Coverage amount (Select all that apply):

Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

180.00

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 5: PACKAGE #1**

Indicate Maximum Plan Benefit Coverage 180.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Other, Describe

Devices and Modifications:

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

Indicate Maximum Plan Benefit Coverage

180.00

amount for Alternative Therapies:

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Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:

Other, Describe

SECTION D. VIDID ALEXCED CT 10D

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

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

BASE 12: PACKAGE #1

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

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

No

No

BASE 14: PACKAGE #1

Is authorization required?
Is a referral required for Other Defined

Supplemental Benefits? Fitness Benefit Notes:*

ITEMS SUCH AS THE FOLLOWING WILL

BE COVERED:

1) PHYSICAL EXERCISE PEDALS

2) STRETCH STRAPS

3) PUZZLES FOR MEMORY FITNESS

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and

Modifications Notes:*

MONTHLY ALLOWANCE.

ITEMS SUCH AS THE FOLLOWING WILL

BE COVERED:

1) MEDICAL BATHMAT

2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

4) REACHER

5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

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CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL

MEDICINE ITEMS.

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

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CARD OF \$50 PER MONTH.

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

: 213

Expected Number of Enrollees to be engaged

44

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

No

amount?

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

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

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Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment? Is authorization required?

Yes

Is a referral required for Other Services?

Yes

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

Notes:

THE INTENTION IS TO UTILIZE A

PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

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

Contrato Número

HEALTH CARE PROFESSIONALS.

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

POPULATION: VBID: PACKAGE #3

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

: Dual-Eligible Status (for territories

Expected Number of Enrollees to be Targeted:

3073

Expected Number of Enrollees to be engaged

3073

and receive Model benefits:

Select LIS reduction level:

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

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

for the Chronically Ill (Other)

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

Are any benefits exempt from the plan-level

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No

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deductible?

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

Is there a package level maximum coverage

No

amount?

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

Notes:

UPON SELECTION OF THE VBID BENEFIT, THE MEMBER WILL BE ELIGIBLE BASED

ON LOW INCOME STATUS

OUALIFICATION FOR THE DUAL

ELIGIBLE SPECIAL NEEDS PLAN. THE BENEFITS ARE INTENDED TO ENHANCE THE QUALITY OF CARE FOR MEDICARE BENEFICIARIES AND/OR IMPROVE THE COORDINATION AND EFFICIENCY OF HEALTH CARE SERVICE DELIVERY AS WELL AS REASONABLE EXPECTATIONS THAT THE ENROLLEES HEALTH OR OVERALL FUNCTION WILL IMPROVE OR BE MAINTAINED BY ACCESS TO THE

BENEFIT.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #3

Select what type of benefit your Non-Primarily

: Food and Produce

Health Related Benefits for the Chronically Ill

: Meals (beyond limited basis) : General Supports for Living

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

Does the plan provide Food and Produce as a

Yes

supplemental benefit under Part C?

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

includes:

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

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

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

Notes:

FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE FOOD AND PRODUCE BENEFIT, THEY WILL BE ELIGIBLE FOR 1 HEALTHY FOOD BOX A MONTH.

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Yes

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #3

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

Select type of benefit for Meals (beyond limited Mandatory

basis):

Is the meal benefit unlimited? No Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

limited basis)?

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

FLEXIBLE SUPPLEMENTAL BENEFITS: IF Notes:

MEMBER SELECTS THE MEALS (BEYOND

LIMITED BASIS), THEY WILL BE

ELIGIBLE FOR UP TO 45 FROZEN MEALS

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PER QUARTER, FOR A MAXIMUM AMOUNT OF 180 FROZEN MEALS A

YEAR.

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

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

Select type of benefit for General Supports for

Living:

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

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

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

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April

Living?

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

Notes: FLEXIBLE SUPPLEMENTAL BENEFITS: IF

MEMBER SELECTS THE SMARTPHONE BENEFIT, THEY WILL RECEIVE ONE SMARTPHONE WITH A VOICE AND DATA PLAN WHILE ENROLLED IN THE PLAN. THE MEMBER WILL HAVE TO RETURN THE SMARTPHONE TO THE MAO IN CASE OF DISENROLLMENT OR CHANGE IN

PLAN COVERAGE.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #3

Select what Other type of benefit your Non-

Primarily Health Related Benefits for the

Chronically Ill includes:

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

Enter name of Service: ADDITIONAL ALLOWANCE FOR DEBIT

CARD

: Other 1

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

50.00

No

Yes

Every month

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

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

Notes:

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FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE ADDITIONAL ALLOWANCE FOR DEBIT CARD, THEY WILL BE ELIGIBLE FOR UP TO \$50 PER MONTH. MEMBER WILL BE ABLE TO USE THE DEBIT CARD FOR THE FOLLOWING SERVICES:

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1. MEALS (BEYOND LIMITED BASIS)-PREPARED FOOD 2. FOOD AND PRODUCE- FOOD & **GROCERIES** 3. GENERAL SUPPORT FOR LIVING-**GASOLINE** 4. PEST CONTROL- CLEANING PRODUCTS 5. SOCIAL NEEDS BENEFITENTERTAINMENT (CONCERTS/THEATER/MOVIES, ETC) 6. GENERAL SUPPORT FOR LIVING-UTILITIES 7. OVER-THE-COUNTER (OTC) ITEMS-ADDITIONAL OTC ITEMS 8. ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) 9. HOME AND BATHROOM SAFETY **DEVICES AND MODIFICATIONS** 10. PART C COPAYMENTS/COINSURANCE 11. NON-PRIMARILY HEALTH RELATED (OTHER)- PET CARE 12. GENERAL SUPPORTS FOR LIVING-GARDENING/HARDWARE ITEMS 13. NON-PRIMARILY HEALTH RELATED (OTHER)- PERSONAL CARE SERVICES, SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES (MANICURE, PEDICURE, HAIRCUT, ETC.), HAIR GROWTH AND ANTI-AGING/SPOT **CREAMS** 14. GENERAL SUPPORTS FOR LIVING-

HOME APPLIANCES
15. GENERAL SUPPORTS FOR LIVINGTOWELS, LINENS AND CLOTHING
16. NON-PRIMARILY HEALTH RELATED
(OTHER)- ADDITIONAL ROADSIDE
ASSISTANCE AND IN-HOME MINOR
REPAIRS AND OTHER SERVICES
17. FITNESS BENEFIT (PHYSICAL
EXERCISE AND MEMORY FITNESS ITEMS

ONLY)

SECTION B: #19C VBID HOSPICE-BASE 1

Is there an enrollee Coinsurance?

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

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription

Yes

5%

5%



	1
.10	at)
100	10

drugs	and	b10	logics:
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Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 2	

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

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

for Medicare covered Benefits for a respite care

Indicate the maximum per day amount 5

SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits? No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

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

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

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

3250.00

5%

: In-Network Medicare-covered benefits

: In-Network Non-Medicare-covered benefits



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Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Does the In-Network Maximum Enrollee Out-

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

Medicare-covered plan services?

Yes

Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

Yes

How many groups of Reductions in Cost

1

Sharing are you offering?

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 1

Select the benefits that apply to the Reductions

in Cost Sharing benefit:

: Medicare-covered benefits

Select which Medicare-Covered Services your

Reductions in Cost Sharing apply to:

: 11a: Durable Medical Equipment (DME)

: 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 2

Indicate Max Plan Benefit amount:

180.00

Select Reductions in Cost Sharing periodicity:

Every month

Can the reduction in cost sharing be applied to a

deductible?

No

What is your Reductions in Cost Sharing mode

of delivery?

: Debit Card

Notes: MONTHLY ALLOWANCE IN THE FORM

OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED

SERVICES IN THE COMBINED PACKAGE. MEMBER IS RESPONSIBLE FOR COSTS

THAT EXCEED THE ALLOWANCE

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Yes

Select the number of Combined Supplemental

Benefit packages you are offering?

3

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are

included in your Combined Supplemental

Benefit package:

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

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

What is your combined supplemental benefits

mode of delivery?

Other Description:

: Other

MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE

ITEMS FROM A CATALOG.

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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: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

What is your combined supplemental benefits mode of delivery?

Other Description:

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: COMBINED BENEFITS #3

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

What is your combined supplemental benefits mode of delivery?

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?

No

Yes

50.00

Every three months

No

: 14c21: In-Home Support Services

: 19b: Additional Benefits for VBID/UF/SSBCI

: Debit Card

DIRECT PAYMENT TO VENDOR

Yes

Yes

50.00

Every month

No

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

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and Modifications

: 14c17: Alternative Therapies

: 19b: Additional Benefits for VBID/UF/SSBCI

: Debit Card

No

Yes

180.00 Every month

No



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SECTION D: NOTES

Notes:



COMBINED BENEFITS #1: THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
 10) SKIN MOISTURIZERS (INCLUDING,
 BUT NOT LIMITED TO FACE, BODY, AND
 FOOT LOTIONS USED FOR DRY SKIN)
 11) SOAP (DOCTOR RECOMMENDED
 ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

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

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:

1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS



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3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM OUANTITY LIMITS IN EACH CATEGORY MAY APPLY. **COMBINED BENEFITS #2:** MEMBERS SELECT TWO (2) OF THE FOLLOWING FLEX BENEFITS REFERENCED IN THE APPLICABLE **SECTION B SUBCATEGORIES:** 1) 14C21: IN-HOME SUPPORT SERVICES, AND/OR 2) 19B-13I: GENERAL SUPPORTS FOR LIVING, AND/OR 3) 19B-13I: FOOD AND PRODUCE, AND/OR 4) 19B-13I: MEALS (BEYOND LIMITED BASIS), AND/OR 5) 19B-13I-OTHER: ADDITIONAL ALLOWANCE FOR DEBIT CARD

COMBINED BENEFITS #3:
MONTHLY ALLOWANCE IN THE FORM
OF A DEBIT CARD. THE DEBIT CARD
ALLOWS THE MEMBER TO ACCESS
ADDITIONAL PRIMARILY HEALTH AND
NON-PRIMARILY HEALTH RELATED
SUPPLEMENTAL BENEFITS, SUCH AS.

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)

Notes:



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> - HOME AND BATHROOM SAFET **DEVICES**

- PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND

OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

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

: Standard Retail : Out-of-Network

Defined Standard

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-counter medications (OTCs) under the utilization management program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

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

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

: Out-of-Network Pharmacy - one month supply

30

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network Pharmacy 1-month supply:

30

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

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 : Standard Mail-Order - 3-month supply

90

: Long-Term Care Pharmacy - 1-month supply

31

No

No

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first fill?

SECTION RX: VBID - GENERAL

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

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 058, SEGMENT 0

Module: **PBP** Requested By: rcqg

PLAN SYSTEM INFORMATION

Last entry Date: 06/01/2022 PBP Software Version: 2023.01

Plan Ready for Upload Timestamp: 06/01/2022 10:18:26 AM SA Western Standard

Time

07/14/2022 02:18:52 PM SA Western Standard MA BPT Timestamp:

Time

PD BPT Timestamp: 06/03/2022 02:57:12 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 07/15/2022 01:39:34 PM SA Western Standard

Time

07/15/2022 #02983 Upload Status:

PLAN STATUS

Section A Status Plan Ready for Upload

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

Section B12 Status 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 Section Mrx Status Completed

SECTION A: SECTION A-1

Section D Status

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Organization Legal Name: MMM HEALTHCARE, LLC

Organization Marketing Name: Medicare y Mucho Mas

Organization Web Site: www.mmmpr.com

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

Organization Type: Local CCP Plan Type: HMO

Enrollee Type:

Part A and Part B

Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

40030 - Aguadilla, PR

40060 - Anasco, PR

Service Area(s):

40070 - Arecibo, PR

Service Area(s):

40140 - Camuy, PR

Service Area(s):

Service Area(s):

40140 - Camuy, PR

40320 - Hatillo, PR

Service Area(s):

40350 - Isabela, PR

40490 - Moca, PR

Service Area(s):

40570 - Quebradillas, PR

Service Area(s): 40580 - Rincon, PR
Service Area(s): 40660 - San Sebastian, PR
Service Area(s): 40710 - Utuado, PR

Contract Number: H4003
Plan ID: 058
Segment ID: 0
Contract Period: 2023

Plan Geographic Name: Puerto Rico Northwest

Is this an Employer-Only plan?

SECTION A: SECTION A-2

Does this Plan have a CMS-approved No

Continuation Area?

Do you intend to participate in the PLATINO Yes

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

Customer Service Contact Phone Number for (866)333-5471

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No

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Current Medicare Beneficiaries:	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required? Yes
Is a referral required for Inpatient Hospital-

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required? Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

C?

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Deductible? No

Is there an enrollee Copayment? No

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

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment? No

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





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No

Mandatory

Yes

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Does the plan provide Worldwide Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: . Worldwide Emergency Coverage

: Worldwide Urgent Coverage

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Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

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

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

500.00 Indicate Maximum Plan Benefit Coverage

amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75,00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No



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of

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes





Is a referral required for Chiropractic Services? Yes SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Is authorization required?

Yes

No

Is a referral required for Occupational Therapy

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Is authorization required?

Select enhanced benefits:

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care?

No

Select the Routine Foot Care periodicity:

Indicate number of Routine Foot Care visits:

Every year

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

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Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

: 7d: Physician Specialist Services



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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required for Additional

No

No

Telehealth Services?

Is a referral required for Additional Telehealth

No

Services?

Notes: ADDITIONAL TELEHEALTH SERVICES

COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

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Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

Is there an enrollee Coinsurance?

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

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

Is authorization required for Medicare-covered

Is a referral required for Medicare-covered

Yes

Observation Services?

No

Outpatient Hospital Services?

No

Is a referral required for Medicare-covered

Is there an enrollee Coinsurance?

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

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

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Ambulatory Surgical No

Center Services?



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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

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

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

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Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Yes

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

No

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Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

Every year

Mandatory

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan One-way

Approved Health-related Location:

Select Mode of Transportation for Plan

Approved Health-related Location: : Rideshare Services

: Bus/Subway : Van

: Taxi

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is there an enrollee Copayment?

No
Do you limit Diabetic Supplies and Services to
those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2





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Yes

No

Yes Is authorization required? Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?

: Number of Treatments Select enhanced benefit:

Select type of benefit for Number of Mandatory Treatments:

Is this benefit unlimited for Number of

Treatments?

Indicate limit for Number of Treatments:

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Yes Is authorization required? Is a referral required for Acupuncture? Yes

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 35.00

amount:

Select Maximum Plan Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Every three months

No

No

Yes

: The Nicotine Replacement Therapy (NRT)

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off

Attestation:

being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE

(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR

- PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH



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CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section. Yes

Select type of benefit for Meals:

Select the type of primarily health related meals

benefit offered:

: Immediately following surgery or inpatient

hospitilization

Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for the Meal Benefit?

Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes: POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

PER YEAR.

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? Yes
Is a referral required? No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

Does the plan provide Other Defined Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c7: Remote Access Technologies (including



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Web/Phone-based technologies and Nursing

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Both Sessions (Individual and Group)

Mandatory

6

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Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Mandatory

Mandatory

Select type of benefit for Fitness Benefit: Indicate type of Fitness Benefit offered (Select : Physical Fitness : Memory Fitness 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):

Select type of benefit for Home and Bathroom Safety Devices and Modifications:

: Nursing Hotline

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

12

Yes

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply): : 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

SMR

Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

35.00

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

Every three months

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

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och

Indicate Maximum Plan Benefit Coverage 35.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Devices and Modifications:

Every three months

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Indicate Maximum Plan Benefit Coverage

35.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:

Every three months

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required? No
Is a referral required for Other Defined No

Supplemental Benefits?

Health Education Notes: THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE

THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN

EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

STRATEGIES, EVALUATE THE RESULTS

AND CREATE FUTURE

GOALS.INTERVENTIONS MIGHT

INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES



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INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS. THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

Fitness Benefit Notes:*



THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

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off

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes: THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE **EDUCATION REGARDING THE** SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS. THE FOLLOWING ITEMS WILL BE **COVERED:**

Home and Bathroom Safety Devices and Modifications Notes:*



1) MEDICAL BATHMAT

2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

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4) REACHER 5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.



THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Kidney Disease

No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

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No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment? No

Is authorization required for Medicare-covered Yes

Glaucoma Screening?

Is authorization required for Medicare-covered Yes

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Yes

Barium Enemas?

Is authorization required for Medicare-covered Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered Yes

EKG following Welcome Visit?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance? No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Ves Is Authorization Required? Does the plan offer step therapy? Yes

Does the benefit step from (select all that : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Restorative Services

: Prosthodontics, Other Oral/Maxillofacial

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Services?

Indicate number of visits for Restorative

Surgery, Other Services

Mandatory

No

Yes

No, indicate number

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1

Services:

Select the Restorative Services periodicity:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other No, indicate number

Services?

Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other

- 1

Services:

Select the Prosthodontics/Other

Other, Describe

Oral/Maxillofacial Surgery/Other Services

periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1500.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

Restorative Services Notes:

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED, REPLACEMENT

CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

PROSTHODONTIC SERVICES:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE

REPAIR SERVICES, INCLUDING

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SERVICES RELATED TO THE REPAÍR ÓF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS. SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH **EVERY 5 YEARS WITH APPROPRIATE** JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.



SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eve Exams as a

EMR

off

supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	750.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No No Contrato Munero 3
Is there an enrollee Coinsurance?	No Residence of State
SECTION B: #17B EYEWEAR - BASE 5	Contrato 0
Is there an enrollee Deductible?	No Y
Is there an enrollee Copayment?	No SEGUROS OU
SECTION B: #17B EYEWEAR - BASE 6	EGUROS
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASI	E1 SMIR



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Yes

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Fitting/Evaluation for

Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

1

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

Is there an enrollee Deductible? No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?

No

Is authorization required? Is a referral required for Hearing Exams? Yes No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all

types):

Mandatory

Is this benefit unlimited for Hearing Aids (all

types)?

Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears

combined?

Both ears combined

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

SEGURO

Indicate Maximum Plan Benefit Coverage

amount:

2500.00

Indicate Maximum Plan Benefit Coverage

Every three years

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SMR

of

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? No Is there an enrollee Deductible? No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

Is a referral required for Hearing Aids? No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section By)

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

Yes

No

No

Yes

Yes

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

: Annual Wellness Visit

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or : Telephonic

more):

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

: In-Person

Yes

Type of Part C Reward or Incentive: : Gift Card : Item

: Item : Other

Reward or Incentive Notes: LIMITED PURPOSE CARD. USAG

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s) 20.00

Frequency of Reward or Incentive Eligibility:

Other, Describe

Other Description:

AVAILABLE

AVAILABLE TO REEDEEM INSTANTLY

OR ACCUMULATE FOR FUTURE

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REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

116

1

No

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

Part C Reward or Incentive Notes:

Part C Reward or Incentive amount(s): Frequency of Reward or Incentive Eligibility:

Other Description:

Eligibility Criteria:

: Gift Card : Item

: Other

LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE

PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN

OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

BENEFICIARIES WITH A QUALIFYING

CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

AACION DE SEGUR

SMR

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT

ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING

DIALYSIS), ALZHEIMER'S (SEVERE OR

LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

Incentives Available:

150.00

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

No

2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

: Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

1667

Expected Number of Enrollees to be engaged

1667

and receive Model benefits:

Select LIS reduction level:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13b: Over-the-Counter (OTC) Items

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

: 13i-O: Non-Primarily Health Related Benefits

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wife

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

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?

325.00

Yes

Select the package level maximum coverage

Specify the maximum benefit amount:

Every month

periodicity:

Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:

: 13b: Over-the-Counter (OTC) Items

: 13i1: Food and Produce

: 13i2: Meals (beyond limited basis)

: 13i3: Pest Control

: 13i6: Social Needs Benefit

: 13i10: General Supports for Living

: 13i-O1: Other 1 Non-Primarily Health Related

Benefit

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORY 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME

APPLIANCES / TOWELS/LINENS AND

CLOTHING / HARDWARE ITEMS)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

(ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)

- ADDITIONAL OTC ITEMS

- ALTERNATIVE THERAPIES

(HOMEOPATHIC / NATURAL MEDICINE

ITEMS ONLY)

- HOME AND BATHROOM SAFETY



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DEVICES

- PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND

OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

325.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is

unused?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Nicotine Replacement Therapy (NRT)

Attestation:

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D

SMR

OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Does this cover all of the OTC list which may

be found in Chapter 4 of the Medicare Managed

Care Manual?

No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

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3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR

PREAUTHORIZATION. 7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT

10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

12) PERSONAL HYGIENE PRODUCTS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Yes

Does the plan provide Food and Produce as a supplemental benefit under Part C?

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandato Yes 325.00

Every month

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

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Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: MONTHLY ALLOWANCE.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?

Yes

Select type of benefit for Meals (beyond limited

Mandatory

basis):

Is the meal benefit unlimited? Yes Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

325.00

amount:

Select Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for the Meals (beyond No

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a supplemental benefit under Part C?

Select type of benefit for Pest Control:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Yes Mandato Yes 325.00

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No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING ITEMS SUCH AS: CLEANING

PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a

supplemental benefit under Part C?

Yes

Select type of benefit for Social Needs Benefit: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

No

Indicate Maximum Plan Benefit Coverage 325.00

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 SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Social Needs Benefit? No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

UNDER THIS CATEGORY WE WILL BE Notes:

> **COVERING ENTERTAINMENT** (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL

GROOMING SERVICES.

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 General Supports for

Living:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Yes



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325.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for

No

Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND CLOTHING, HARDWARE ITEMS.

GUROS

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-Primarily Health Related Benefits for the : Other 1 : Other 2

Chronically Ill includes:

: Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:

Select type of benefit for Other 1:

Is there a service-specific Maximum Plan
Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

325.00

amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED

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BENEFIT - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS,

GROOMING ITEMS AND SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service: PERSONAL CARE ITEMS

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 325.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

No

Every month

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 2 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED

BENEFIT - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-

AGE / SPOT CREAMS.

ADMIN,

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Yes

No

300.00

Other, Describ

Enter name of Service: ROADSIDE ASSISTANCE, IN-HOME

MINOR REPAIRS AND OTHER

Select type of benefit for Other 3: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Other 3 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #1**

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS* 3. PEST CONTROL (1 PER QTR.) 4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.) 5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)



*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE \$325 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIS AND OTHER SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 1: PACKAGE #1**

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?

Yes

Select enhanced benefit (Select all that apply):

: 14c4: Fitness Benefit*

114c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness

all that apply):

: Memory Fitness

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M

Select type of benefit for Home and Bathroom

Mandatory

Safety Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

: 14c4: Fitness Benefit

Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):

: 14c8: Home and Bathroom Safety Devices and

SMR

Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

325.00

amount for Fitness Benefit:

Select Maximum Plan Benefit Coverage

Monthly

periodicity for Fitness Benefit:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage

325.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety

Other, Describe

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 6: PACKAGE #1

Indicate Maximum Plan Benefit Coverage

325.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 10: PACKAGE #1

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 12: PACKAGE #1

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 14: PACKAGE #1**

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Fitness Benefit Notes:*

ITEMS SUCH AS THE FOLLOWING WILL

BE COVERED:

1) PHYSICAL EXERCISE PEDALS

2) STRETCH STRAPS

3) PUZZLES FOR MEMORY FITNESS

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 15: PACKAGE #1**

Home and Bathroom Safety Devices and

MONTHLY ALLOWANCE.

Modifications Notes:*

ITEMS SUCH AS THE FOLLOWING WILL

BE COVERED:

1) MEDICAL BATHMAT

2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

4) REACHER

5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #1

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL

MEDICINE ITEMS.

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted:

116

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wh

Expected Number of Enrollees to be engaged

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

24

No

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

No

amount?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:

NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes: THE INTENTION

THE INTENTION IS TO UTILIZE A

PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY

HEALTH CARE PROFESSIONALS.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?

Yes

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Indicate the Minimum Coinsurance percentage

5%

	1
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2	
/	

for Medicare covered Benefits for prescription drugs and biologics:	
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETW	ORK)
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT	(IN-NETWORK)
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-	Lower



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Pocket (MOOP) Cost at the Lower, Intermediate

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or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Medicare-covered plan services?

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

Yes

3250.00

Yes

No

Yes

2

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Select the number of Combined Supplemental

Benefit packages you are offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental

Benefit package:

: 13b: Over-the-Counter (OTC) Items

: In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

What is your combined supplemental benefits

mode of delivery?

Other Description:

: Other

MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE

ITEMS FROM A CATALOG.

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: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental

Benefit package:

Yes

No

35.00

Every three months

No

: 13b: Over-the-Counter (OTC) Items

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and Modifications

: 14c17: Alternative Therapies

: 19b: Additional Benefits for VBID/UF/SSBCI

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What is your combined supplemental benefits mode of delivery?

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:

: Debit Card

No

Yes

325.00

Every month

No

COMBINED BENEFITS #1: THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT
- DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING,
- 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED
- ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD

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- 4) REACHER
- 5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

COMBINED BENEFITS #2:
MONTHLY ALLOWANCE IN THE FORM
OF A DEBIT CARD. THE DEBIT CARD
ALLOWS THE MEMBER TO ACCESS
ADDITIONAL PRIMARILY HEALTH AND
NON-PRIMARILY HEALTH RELATED
SUPPLEMENTAL BENEFITS, SUCH AS.

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES

Notes:



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- PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Yes

Select the type of drug benefit:

Defined Standard : Standard Retail

Describe the components of your pharmacy

: Out-of-Network

network (select all that apply):

: Standard Mail-Order : Long-Term Care

Sponsor attests that it will comply with 42 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?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:

: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

90

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?

SECTION RX: VBID - GENERAL

: Out-of-Network Pharmacy - one month supply

30

: Standard Mail-Order - 3-month supply

90

: Long-Term Care Pharmacy - 1-month supply

No

31

110

No

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Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No



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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, SEGMENT 0

Module: PBP

Requested By: rcqg

PLAN SYSTEM INFORMATION

Last entry Date: 06/01/2022 PBP Software Version: 2023.01

Plan Ready for Upload Timestamp: 06/01/2022 12:33:19 PM SA Western Standard

Time

MA BPT Timestamp: 07/14/2022 12:45:22 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2022 02:57:42 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 07/15/2022 01:39:34 PM SA Western Standard

Time

Upload Status: 07/15/2022 #02983

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Section B7 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 B13 Status Completed
Section B14 Status Completed

Section B15 Status Completed
Section B16 Status Completed

Section B17 Status Completed
Section B18 Status Completed

Section B19 Status Completed
Section C Status Completed

Section C Status Completed
Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1



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MMM HEALTHCARE, LLC Organization Legal Name: Organization Marketing Name: PMC Medicare Choice

www.mmmpr.com Organization Web Site:

PMC Premier Platino (HMO D-SNP) Plan Name:

Local CCP Organization Type:

Plan Type:

Enrollee Type: Service Area(s): 40010 - Adjuntas, PR

Service Area(s): 40030 - Aguadilla, PR Service Area(s):

Service Area(s): Service Area(s):

Service Area(s): 40060 - Anasco, PR 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR Service Area(s):

Service Area(s): 40100 - Barranquitas, PR Service Area(s):

Service Area(s): Service Area(s): 40120 - Cabo Rojo, 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): Service Area(s): 40170 - Cayey, PR

40190 - Ciales, PR Service Area(s): 40200 - Cidra, PR Service Area(s): Service Area(s):

40220 - Comerio, PR Service Area(s):

Service Area(s): Service Area(s):

Service Area(s):

Service Area(s): Service Area(s):

40270 - Guanica, PR Service Area(s):

Service Area(s): 40280 - Guayama, PR

40290 - Guayanilla, PR Service Area(s):

Service Area(s): Service Area(s):

Service Area(s):

Service Area(s):

Service Area(s):

HMO

Part A and Part B

40020 - Aguada, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40090 - Barceloneta, PR

40110 - Bayamon, PR

40130 - Caguas, PR

40180 - Ceiba, PR

40210 - Coamo, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



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40330 - Hormigueros, PR Service Area(s): 40340 - Humacao, PR Service Area(s): 40350 - Isabela, PR 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 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 40470 - Maunabo, PR Service Area(s): Service Area(s): 40480 - Mayaguez, PR

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):

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): 40640 - San Juan, PR Service Area(s):

Service Area(s): 40650 - San Lorenzo, PR

40660 - San Sebastian, PR Service Area(s):

40670 - Santa Isabel, PR Service Area(s):

Service Area(s): 40680 - Toa Alta, PR 40690 - Toa Baja, PR Service Area(s):

40700 - Trujillo Alto, PR Service Area(s):

Service Area(s): 40710 - Utuado, PR

40720 - Vega Alta, PR Service Area(s):

40730 - Vega Baja, PR Service Area(s):

Service Area(s): 40740 - Vieques, PR

Service Area(s):



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	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H4004	
Plan ID:	048	
Segment ID:	0	
Contract Period:	2023	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No	
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		
Participating Pharmacy Website Address:	www.mmmpr.com	
Formulary Website Address:	www.mmmpr.com	
Physician Website Address:	www.mmmpr.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	OF Contrato Número
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	A Coutrato Mirmero
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	S Coultan 0 0
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471	GUROS OF
SECTION A: SECTION A-4		A CONTRACTOR OF THE PARTY OF TH
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact TTY for Current	(711)-	ZMK

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April

Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Prospective Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

Customer Service Contact Local TTY for (711)-

Current Part D Medicare Beneficiaries:

Customer Service Contact TTY for Prospective (711)-

Part D Medicare Beneficiaries:

Customer Service Contact TTY for Current Part (711)-

D Medicare Beneficiaries:

SECTION A: SECTION A-5

Is your organization filing a standard bid for No

Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for No

Section D of the PBP?

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered

in Section B of the PBP software)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part

C?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay

period?

Do you charge cost sharing on the day of No



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No

De

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee No

obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part No

C2

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

•

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost

No

sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

1 41

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? **SECTION B: #2 SNF - BASE 10**

No



What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Corromagas

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent

Yes

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Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

No

No

500.00

Is there an enrollee Coinsurance?

Is there an enrollee Copayment? Yes

Select which Worldwide Services have a : Worldwide Emergency Coverage Copayment (Select all that apply): : Worldwide Urgent Coverage

Indicate Minimum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide Yes

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for \$75.00

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide Yes

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes
Is a referral required for Partial Hospitalization? Yes
SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Home Health Services? No





SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care

Select enhanced benefit: Select type of benefit for Routine Care:

Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care:

6

Select Routine Care periodicity:

Every year

Is there a service-specific Maximum Plan

Yes

No

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

750.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is authorization required?

Yes

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

INO

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE

Is authorization required? Yes
Is a referral required for Occupational Therapy Yes

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?



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Is there an enrollee Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?

No

No

Is a referral required for Physician Specialist

Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Mental Health

Yes

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

No

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No
SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Podiatrist Services? Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?

Yes





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Is a referral required for Other Health Care

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Yes

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Psychiatric Services? Yes

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Nο Is there an enrollee Coinsurance? Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required? Yes No

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit

for Part B services?

: 7d: Physician Specialist Services Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

ADDITIONAL TELEHEALTH SERVICES Notes:

> COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

CLINICS.

Yes

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Opioid Treatment No

Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

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Africa

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Ambulatory Surgical

No

Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient Substance Yes

Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2



Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location Select enhanced benefit:

Yes

Yes

No

Mandatory

Every year

One-way

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved 24

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan

Approved Health-related Location:

Select Mode of Transportation for Plan

: Taxi

Approved Health-related Location: : Rideshare Services

: Bus/Subway

: Van

SECTION R: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No No Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? Yes

Is a referral required for Transportation No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?





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Is authorization required?

Yes

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required? Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment? No Do you limit Diabetic Supplies and Services to No those from specified manufacturers?

Is authorization required? Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 500.00

amount:

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Select Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

No

Yes

No

No

Yes

No No

No

No

Every month

Every year

SECTION B: #13A ACUPUNCTURE - BASE 2

No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No No Is there an enrollee Copayment? Is authorization required? Yes Is a referral required for Acupuncture? Yes

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE **COVERED:**

: The Nicotine Replacement Therapy (NRT)

being offered does not duplicate any Part D

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES

OTC or formulary drugs.

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

EMR

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4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE

(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR

PREAUTHORIZATION.

7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING,
BUT NOT LIMITED TO FACE, BODY, AND
FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED
ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for Meals:

Select the type of primarily health related meals benefit offered:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No

Yes



Mandatory

: Immediately following surgery or inpatient hospitilization

No

No

EMR

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Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for the Meal Benefit?

Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes: POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

PER YEAR.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

No

Yes

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? Yes Is a referral required? No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

Mandatory

: 14c8: Home and Bathroom Safety Devices and

GUROS

Modifications*

: 14c17: Alternative Therapies*

: 14c21: In-Home Support Services*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Beneiit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Mandatory

No, indicate number

Both Sessions (Individual and Group)

Mandatory

9

6

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Mandatory

: Nursing Hotline

Select type of benefit for Fitness Benefit: Mandatory

Indicate type of Fitness Benefit offered (Select : Physical Fitness all that apply): : Memory Fitness

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Home and Bathroom Mandatory

Safety Devices and Modifications:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Select type of benefit for In-Home Support Mandatory

Services:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit : 14c8: Home and Bathroom Safety Devices and

Coverage amount (Select all that apply): Modifications

: 14c17: Alternative Therapies

Coupust

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

Monthly

Other, Describe

200.00

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage 200.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage

periodicity for Home and Bathroom Safety

Devices and Modifications:

eriodicity for from and Baumoom Safety

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE

Indicate Maximum Plan Benefit Coverage 200.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee No

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Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?

Yes

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS **EDUCATIONAL INTERVENTIONS BASED** ON DIAGNOSIS SUCH AS DIABETES. HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES. PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

STRATEGIES, EVALUATE THE RESULTS

AND CREATE FUTURE

GOALS.INTERVENTIONS MIGHT

INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE

EDUCATORS PROVIDE INFORMATION TO

IMPROVE THE MEMBER'S SKILL

SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED

INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE

ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL

INTERVENTIONS.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE

GUROS

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

off

OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING, IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A OUIT DATE, REDUCE OUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes: THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS, HEALTH

Fitness Benefit Notes:*



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PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS. THE FOLLOWING ITEMS WILL BE

Home and Bathroom Safety Devices and Modifications Notes:*





1) MEDICAL BATHMAT

- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER

COVERED:

5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

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Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH

CATEGORY MAY APPLY.

In-Home Support Services Notes:* FLEXIBLE SUPPLEMENTAL BENEFITS: IF

MEMBER SELECTS THE IN-HOME SUPPORT SERVICES BENEFIT, THEY WILL BE ELIGIBLE FOR UP TO 4-HOUR IN-HOME CARE VISITS (UP TO 24 HRS. PER QUARTER, FOR A MAXIMUM

AMOUNT OF 96 HRS. TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY

ROS

LIVING. PA MAY APPLY,

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Kidney Disease

No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment? No

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Is authorization required for Medicare-covered

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Yes

Yes

Yes

Is authorization required for Medicare-covered

Digital Rectal Exams?

Yes

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is there an enrollee Coinsurance?

Yes

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket

Cost?

No

Nα

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Yes Is Authorization Required? Does the plan offer step therapy? Yes

Does the benefit step from (select all that : Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Restorative Services

Select enhanced benefits:

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

1

Indicate number of visits for Restorative

Select the Restorative Services periodicity:

Services:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other Mandatory SMR

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Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

Other, Describe

1

No, indicate number

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Yes

Plan-specified amount per period

Every year

3000.00

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

SMR

Is authorization required?

Yes Is a referral required for Comprehensive Dental No

Services?

Restorative Services Notes:

CORE BUILDUP AND PIN RETENTION PER

TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT **CROWNS COVERED EVERY 5 YEARS PER**

TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

PROSTHODONTIC SERVICES:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE,

COVERED EVERY 5 YEARS. DENTURE

REPAIR SERVICES, INCLUDING

SERVICES RELATED TO THE REPAIR OF

EXISTING COMPLETE OR PARTIAL

DENTURES ARE COVERED. REMOVABLE

PARTIAL FLEXIBLE BASE DENTURES



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(SUCH AS: VALPLAST) COVERED EVERY 5 YEARS, RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR. RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS. SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH **EVERY 5 YEARS WITH APPROPRIATE** JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES. IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

No

EMR No



SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Yes
Is a referral required for Eye Exams?

No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Yes

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

Select type of benefit for Contact lenses: Mandatory

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and

frames):

Mandatory

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Yes

Yes

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit 600.00

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear? No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid

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Yes

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

1

No

No

Mandatory

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there an enrollee Deductible? No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

: Hearing Aids (all types)

Select enhanced benefits:

Mandatory

Yes

Select type of benefit for Hearing Aids (all types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears

combined?

Both ears combined

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

8 MR

Indicate Maximum Plan Benefit Coverage

amount:

2500.00

Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #18B HEARING AIDS - BASE 4

GUROS

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No

No Is there an enrollee Copayment? Is there an enrollee Deductible? No

SECTION B: #18B HEARING AIDS - BASE 5

Yes Is authorization required? No Is a referral required for Hearing Aids?

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Are you offering a VBID Hospice Benefit? Yes Yes Are you offering Part C benefits under the

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

: Telephonic

: In-Person

: Gift Card

Yes

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

: Annual Wellness Visit WHP Program Type (choose one or more):

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

Type of Part C Reward or Incentive:

: Item

: Other

LIMITED PURPOSE CARD. USAGE WILL Reward or Incentive Notes:

> BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

20.00 Part C Reward or Incentive amount(s)

Frequency of Reward or Incentive Eligibility: Other, Describe

SMR

AVAILABLE TO REEDEEM INSTANTLY Other Description:

OR ACCUMULATE FOR FUTURE

REDEMPTION, ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT.

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Does your organization offer provider incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

No

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

687

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive:

: Gift Card

: Item

: Other

Part C Reward or Incentive Notes: LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN

CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s):

Frequency of Reward or Incentive Eligibility:

Other Description:

130.00

Other, Describe

PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN

OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

Eligibility Criteria:

BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO

RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.



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ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

Incentives Available:

150.00

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity No Flexibility/SSBCI benefit offer Part C

reductions in cost?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional 3

Benefits contain? (1-15)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

EMR

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 9893 Expected Number of Enrollees to be engaged 9893

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13b: Over-the-Counter (OTC) Items

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically III (Other)

: 14c: Other Defined Supplemental Benefits

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage

Yes

amount?

Specify the maximum benefit amount:

65.00

Select the package level maximum coverage

Every month

periodicity:

Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:

: 13b: Over-the-Counter (OTC) Items

: 13i1: Food and Produce

: 13i2: Meals (beyond limited basis)

: 13i3: Pest Control

: 13i6: Social Needs Benefit

: 13i10: General Supports for Living

: 13i-O1: Other 1 Non-Primarily Health Related

Benefit

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

EMBEDDED SUPPLEMENTAL BENEFITS:
MONTHLY ALLOWANCE IN THE FORM
OF A DEBIT CARD WILL BE AVAILABLE
TO BE USED FOR ALL PRIMARILY AND
NON-PRIMARILY HEALTH RELATED
SERVICES INCLUDED WITHIN VBID
PACKAGES IN CATEGORY 19B, SUCH AS:

- FOOD & GROCERIES

- MEALS BEYOND LIMITED BASIS

(PREPARED FOOD)

- GENERAL SUPPORTS FOR LIVING

(GASOLINE / UTILITIES / HOME

APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)

- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT

(ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING

ITEMS / GROOMING SERVICES)

- ADDITIONAL OTC ITEMS

- ALTERNATIVE THERAPIES

(HOMEOPATHIC / NATURAL MEDICINE

ITEMS ONLY)

- HOME AND BATHROOM SAFETY

DEVICES



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- PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND

OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

FLEXIBLE SUPPLEMENTAL BENEFITS: ADDITIONAL MONTHLY ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

EMBEDDED SUPPLEMENTAL BENEFITS: ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 65.00

amount:

Select Maximum Plan Benefit Coverage Every

periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

Every month

No

Yes

No

Yes

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

EMR

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes: THE FOLLOWING HEALTH & NON

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HEALTH RELATED CATEGORIES ARE COVERED:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
- 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT
 10) SKIN MOISTURIZERS (INCLUDING,
 BUT NOT LIMITED TO FACE, BODY, AND
 FOOT LOTIONS USED FOR DRY SKIN)
 11) SOAP (DOCTOR RECOMMENDED
 ANTIBACTERIAL/ANTIMICROBIAL SOAP)
 12) PERSONAL HYGIENE PRODUCTS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.



Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

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Indicate Maximum Plan Benefit Coverage

amount:

65.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE

COVERING PREPARED FOOD.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?

Mandatory

Select type of benefit for Meals (beyond limited

basis):

No

Yes

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Is the meal benefit unlimited?

65.00

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Other, Describe

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for the Meals (beyond No limited basis)?

SMR

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:

2 MEALS PER DAY, FOR 10 DAYS, UP TO 1

TIME PER YEAR, FOR 20 MEALS MAX PER YEAR.

ALSO INCLUDES A MONTHLY ALLOWANCE FOR THE PURCHASE OF PREPARED FOOD / ADDITIONAL MEALS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

Contrato Número

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a supplemental benefit under Part C?

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE **COVERING ITEMS SUCH AS: CLEANING**

PRODUCTS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

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CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a

Yes

supplemental benefit under Part C?

Select type of benefit for Social Needs Benefit: Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

amount:

Select Maximum Plan Benefit Coverage

Every month

Mandatory

periodicity:

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No

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Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Social Needs Benefit?

No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL

GROOMING SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

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CARD OF \$50 PER MONTH.

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?

Mandatory

Yes

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 65.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for
No

Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND

wh

CLOTHING, HARDWARE ITEMS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

: Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:

PET CARE

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

Indicate Maximum Plan Benefit Coverage

Yes

Benefit Coverage amount?

65.00

amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Out-of-Pocket Cost?

Is there a service-specific Maximum Enrollee

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:

PERSONAL CARE ITEMS

Select type of benefit for Other 2:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

65.00

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amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 2 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE

COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-

AGE / SPOT CREAMS.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service: ROADSIDE ASSISTANCE, IN-HOME

MINOR REPAIRS AND OTHER

Select type of benefit for Other 3:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 300.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 3 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

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EMBEDDED SUPPLEMENTAL BENEFIT:

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Notes:

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MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS* 3. PEST CONTROL (1 PER QTR.) 4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.) 5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

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IN ADDITION, MEMBER CAN USE THE \$65 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 1: PACKAGE #1**

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?

Yes

Select enhanced benefit (Select all that apply):

: 14c4: Fitness Benefit*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Fitness Benefit:

Mandatory

Indicate type of Fitness Benefit offered (Select

: Physical Fitness

all that apply):

: Memory Fitness

Select type of benefit for Home and Bathroom

Mandatory

Safety Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 2: PACKAGE #1

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Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Yes

65.00

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit : 14c8: Home and Bathroom Safety Devices and

Coverage amount (Select all that apply): Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

Select Maximum Plan Benefit Coverage Monthly

periodicity for Fitness Benefit:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage 65.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 6: PACKAGE #1

Indicate Maximum Plan Benefit Coverage

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

periodicity for Alternative Therapies:

Other, Describe

No

65.00

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 12: PACKAGE #1

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 14: PACKAGE #1

Is authorization required? No Is a referral required for Other Defined No

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Supplemental Benefits?

Fitness Benefit Notes:*

ITEMS SUCH AS THE FOLLOWING WILL BE COVERED:

1) PHYSICAL EXERCISE PEDALS

2) STRETCH STRAPS

3) PUZZLES FOR MEMORY FITNESS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*

MONTHLY ALLOWANCE.

ITEMS SUCH AS THE FOLLOWING WILL BE COVERED:

1) MEDICAL BATHMAT 2) RAISED TOILET SEAT

3) HANDHELD SHOWER HEAD

4) REACHER 5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.



UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF \$50 PER MONTH.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?

about:blank

VBID

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or

both:

: Chronic Condition(s)

Which disease states does this benefit apply?

: Diabetes

(Select all that apply):

Expected Number of Enrollees to be Targeted: 687
Expected Number of Enrollees to be engaged 142

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits No

for this package?

Select all the Non-Medicare-covered additional : 13d: Other 1

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

No

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

amount?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes: NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional): NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Other Services?

Yes

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes:

THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE

MONITORING (CGM) DEVICE INDICATED

FOR DETECTING TRENDS AND

TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW

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THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #3

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #3

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted:

9893

Expected Number of Enrollees to be engaged

9893

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #3

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13i-O: Non-Primarily Health Related Benefits

benefits offered in this package:

for the Chronically Ill (Other)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #3

Is there a package level maximum coverage

No

amount?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes:

UPON SELECTION OF THE VBID BENEFIT, THE MEMBER WILL BE ELIGIBLE BASED

ON LOW INCOME STATUS

QUALIFICATION FOR THE DUAL ELIGIBLE SPECIAL NEEDS PLAN. THE BENEFITS ARE INTENDED TO ENHANCE THE QUALITY OF CARE FOR MEDICARE BENEFICIARIES AND/OR IMPROVE THE COORDINATION AND EFFICIENCY OF HEALTH CARE SERVICE DELIVERY AS WELL AS REASONABLE EXPECTATIONS THAT THE ENROLLEES HEALTH OR

OVERALL FUNCTION WILL IMPROVE OR BE MAINTAINED BY ACCESS TO THE

BENEFIT.



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SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #3

Select what Other type of benefit your Non-

: Other 1

Primarily Health Related Benefits for the

Chronically Ill includes:

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #3

Enter name of Service: ADDITIONAL ALLOWANCE FOR DEBIT

CARD

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #3

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #3

Notes: FLEXIBLE SUPPLEMENTAL BENEFITS: IF

MEMBER SELECTS THE ADDITIONAL ALLOWANCE FOR DEBIT CARD, THEY WILL BE ELIGIBLE FOR UP TO \$50 PER MONTH. MEMBER WILL BE ABLE TO USE THE DEBIT CARD FOR THE FOLLOWING

SERVICES:

1. MEALS (BEYOND LIMITED BASIS)-

PREPARED FOOD

2. FOOD AND PRODUCE- FOOD &

GROCERIES

3. GENERAL SUPPORT FOR LIVING-

GASOLINE

4. PEST CONTROL- CLEANING PRODUCTS

5. SOCIAL NEEDS

BENEFITENTERTAINMENT

(CONCERTS/THEATER/MOVIES, ETC)

6. GENERAL SUPPORT FOR LIVING-

UTILITIES



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7. OVER-THE-COUNTER (OTC) ITEMS-ADDITIONAL OTC ITEMS 8. ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) 9. HOME AND BATHROOM SAFETY **DEVICES AND MODIFICATIONS** 10. PART C COPAYMENTS/COINSURANCE 11. NON-PRIMARILY HEALTH RELATED (OTHER)- PET CARE 12. GENERAL SUPPORTS FOR LIVING-GARDENING/HARDWARE ITEMS 13. NON-PRIMARILY HEALTH RELATED (OTHER)- PERSONAL CARE SERVICES, SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES (MANICURE, PEDICURE, HAIRCUT, ETC.), HAIR GROWTH AND ANTI-AGING/SPOT CREAMS 14. GENERAL SUPPORTS FOR LIVING-**HOME APPLIANCES** 15. GENERAL SUPPORTS FOR LIVING-TOWELS, LINENS AND CLOTHING 16. NON-PRIMARILY HEALTH RELATED (OTHER)- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES 17. FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?

Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:

Indicate the maximum per drug amount

Is there an enrollee Copayment?

Is there an enrollee Coinsurance?

Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:

Indicate the maximum per day amount

Yes

5%

5%

5 No Yes

5%

5%

5

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SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription	5%
drugs and biologics:	
Indicate the Maximum Coinsurance percentage	5%
for Medicare covered Benefits for prescription	
drugs and hiologics:	

drugs and biologics: 5 Indicate the maximum per drug amount No Is there an enrollee Copayment? Is there an enrollee Coinsurance? Yes

Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:

Indicate the maximum per day amount

SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits? No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

Yes

Lower

Yes

Yes

5%

5%

5

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate

or Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3250.00

Select the benefits that apply to the In-Network

: In-Network Medicare-covered benefits Maximum Enrollee Out-of-Pocket cost: : In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Medicare-covered plan services?

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network Non-

Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Yes





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Select the number of Combined Supplemental Benefit packages you are offering?

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

What is your combined supplemental benefits mode of delivery?

Other Description:

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: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

What is your combined supplemental benefits mode of delivery?

Other Description:

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: COMBINED BENEFITS #3

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:

: 13b: Over-the-Counter (OTC) Items

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

: Other

MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.

No

Yes

200.00

Every month

No

: 14c21: In-Home Support Services

: 19b: Additional Benefits for VBID/UF/SSBCI

: Debit Card : Other

DIRECT PAYMENT TO VENDOR

Yes

Yes

50.00

Every month

No

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: 13b: Over-the-Counter (OTC) Items

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

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What is your combined supplemental benefits mode of delivery?

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:

: 19b: Additional Benefits for VBID/UF/SSBCI

: Debit Card

No

Yes

65.00

Every month

No

COMBINED BENEFITS #1: THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR

PREAUTHORIZATION.
7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED

11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

1) MEDICAL BATHMAT 2) RAISED TOILET SEAT



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- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS

MEDICINE ITEMS

3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
COMBINED BENEFITS #2:
MEMBERS SELECT ONE (1) OF THE FOLLOWING FLEX BENEFITS REFERENCED IN THE APPLICABLE SECTION B SUBCATEGORIES:
1) 14C21: IN-HOME SUPPORT SERVICES, AND/OR
2) 19B-13I-OTHER: ADDITIONAL ALLOWANCE FOR DEBIT CARD

COMBINED BENEFITS #3:
MONTHLY ALLOWANCE IN THE FORM
OF A DEBIT CARD. THE DEBIT CARD
ALLOWS THE MEMBER TO ACCESS
ADDITIONAL PRIMARILY HEALTH AND
NON-PRIMARILY HEALTH RELATED
SUPPLEMENTAL BENEFITS, SUCH AS.

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)

Notes:



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- PEST CONTROL (CLEANING PRODUCTS)

- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING

ITEMS / GROOMING SERVICES)

- ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES

(HOMEOPATHIC / NATURAL MEDICINE

ITEMS ONLY)

- HOME AND BATHROOM SAFETY

DEVICES - PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND

OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

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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):

Sponsor attests that it will comply with 42 CFR 423.154.

Yes

Defined Standard : Standard Retail

: Out-of-Network

: Standard Mail-Order

: Long-Term Care

ROSD : 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?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

: Standard Retail Cost Sharing - 1 month Supply

: Standard Retail Cost Sharing - 3 month Supply

30

90

: Out-of-Network Pharmacy - one month supply

30

90

: Standard Mail-Order - 3-month supply

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Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:

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?

: Long-Term Care Pharmacy - 1-month supply

31

No

No

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No



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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 062, SEGMENT 0

Module: PBP Requested By: rcqg

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2022 PBP Software Version: 2023.01

Plan Ready for Upload Timestamp: 06/03/2022 11:42:19 AM SA Western Standard

Time

MA BPT Timestamp: 07/14/2022 02:21:50 PM SA Western Standard

Time

PD BPT Timestamp: 07/15/2022 10:29:30 AM SA Western Standard

Time

Last Upload File Creation Timestamp: 07/15/2022 01:39:34 PM SA Western Standard

Time

Upload Status: 07/15/2022 #02983

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Completed Section B10 Status 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 C Status Completed
Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1

Section B19 Status



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Completed

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MMM HEALTHCARE, LLC Organization Legal Name:

PMC Medicare Choice Organization Marketing Name: Organization Web Site: www.mmmpr.com

MMM Relax Platino (HMO D-SNP) Plan Name:

Local CCP Organization Type:

Plan Type: **HMO**

Enrollee Type: 40010 - Adjuntas, PR Service Area(s): 40020 - Aguada, PR Service Area(s): Service Area(s):

40040 - Aguas Buenas, PR Service Area(s):

Service Area(s): 40060 - Anasco, PR Service Area(s): Service Area(s): 40080 - Arroyo, PR Service Area(s):

40090 - Barceloneta, PR Service Area(s): 40100 - Barranquitas, PR Service Area(s): Service Area(s): 40110 - Bayamon, PR

40120 - Cabo Rojo, PR Service Area(s): 40130 - Caguas, PR Service Area(s):

40140 - Camuy, PR Service Area(s): 40145 - Canovanas, PR Service Area(s):

40150 - Carolina, PR Service Area(s): 40160 - Catano, PR Service Area(s): Service Area(s):

40180 - Ceiba, PR Service Area(s): 40190 - Ciales, PR Service Area(s):

40200 - Cidra, PR Service Area(s):

Service Area(s): Service Area(s): 40220 - Comerio, PR

40230 - Corozal, PR Service Area(s):

Service Area(s): 40250 - Dorado, PR

Service Area(s):

Service Area(s): 40265 - Florida, PR Service Area(s):

Service Area(s):

40280 - Guayama, PR Service Area(s):

Service Area(s):

Service Area(s): 40310 - Gurabo, PR Service Area(s):

40320 - Hatillo, PR Service Area(s):

Service Area(s):

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Part A and Part B

40030 - Aguadilla, PR

40050 - Aibonito, PR

40070 - Arecibo, PR

40170 - Cayey, PR

40210 - Coamo, PR

40240 - Culebra, PR

40260 - Fajardo, PR

40270 - Guanica, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR





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40330 - Hormigueros, PR

40340 - Humacao, PR

40350 - Isabela, PR

40360 - Jayuya, PR

40370 - Juana Diaz, PR

40380 - Juncos, PR

40390 - Lajas, PR

40400 - Lares, PR

40410 - Las Marias, PR

40420 - Las Piedras, PR

40430 - Loiza, PR

40440 - Luquillo, PR

40450 - Manati, PR

40460 - Maricao, PR

40470 - Maunabo, PR

40480 - Mayaguez, PR

40490 - Moca, PR

40500 - Morovis, PR

40510 - Naguabo, PR

40520 - Naranjito, PR

40530 - Orocovis, PR

40540 - Patillas, PR

40550 - Penuelas, PR

40560 - Ponce, PR

40570 - Quebradillas, PR

40580 - Rincon, PR

40590 - Rio Grande, PR

40610 - Sabana Grande, PR

40620 - Salinas, PR

40630 - San German, PR

40640 - San Juan, PR

40650 - San Lorenzo, PR

40660 - San Sebastian, PR

40670 - Santa Isabel, PR

40680 - Toa Alta, PR

40690 - Toa Baja, PR

40700 - Trujillo Alto, PR

40710 - Utuado, PR

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR

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Service Area(s): Service Area(s):

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	40750 - Villalba, PR	-1
Service Area(s):	40760 - Yabucoa, PR	WA)
Service Area(s):	40770 - Yauco, PR	2 10
Contract Number:	H4004	
Plan ID:	062	
Segment ID:	0	
Contract Period:	2023	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No	
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		
Participating Pharmacy Website Address:	www.mmmpr.com	
Formulary Website Address:	www.mmmpr.com	
Physician Website Address:	www.mmmpr.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396	A Contrato Número
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471	S Contrato Número
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396	23-07
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471	HGUROS DE
SECTION A: SECTION A-4		
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396	EMR
Customer Service Contact TTY for Current	(711)-	

Medicare Beneficiaries:			
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-		
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-		
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-		
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-		
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-		
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-		
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-		
SECTION A: SECTION A-5			
Is your organization filing a standard bid for Section B of the PBP?	No		
Is your organization filing a standard bid for Section C of the PBP?	No		
SECTION A: SECTION A-6			
Is your organization filing a standard bid for Section D of the PBP?	No		
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BA			
Does the plan provide Inpatient Hospital-Acute	No		

ASE 1

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part

Is there a service-specific Maximum Enrollee

Is there an enrollee Coinsurance?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

No

No

No

Per Admission or Per Stay

Out-of-Pocket Cost? Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee obtains care?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit period? Do you charge cost sharing on the day of





discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Hospital-

No

Acute Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee No

obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

 \mathbb{C} ?

Do you allow less than 3 day inpatient hospital

Yes

stay prior to SNF admission?

Zero

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in No

which an enrollee obtains care?

110

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No

SECTION B: #2 SNF - BASE 10

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What is your SNF benefit period?

Per Admission or Per Stay

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

Yes

Is a referral required for SNF Services?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental

benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Yes

Rehabilitation Services?

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?

Nο

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C? Select enhanced benefit: : Worldwide Emergency Coverage : Worldwide Urgent Coverage

Mandator

Select type of benefit for Worldwide Emergency

Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

Yes

amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

amount:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

500.00

No

No

Yes

\$75.00

\$75.00

\$75.00

\$75.00

Yes

No

No

No No

Yes

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Select which Worldwide Services have a

Copayment (Select all that apply):

Indicate Minimum Copayment amount for

Worldwide Emergency Coverage:

Indicate Maximum Copayment amount for

Worldwide Emergency Coverage:

Is this Copayment waived for Worldwide

Emergency Coverage if admitted to hospital?

Indicate Minimum Copayment amount for

Worldwide Urgent Coverage:

Indicate Maximum Copayment amount for

Worldwide Urgent Coverage:

Is this Copayment waived for Worldwide

Urgent Coverage if admitted to hospital?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

Yes

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Home Health Services? No



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SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care
Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 750.00

amount:

Select Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is authorization required?

Yes
Is a referral required for Chiropractic Services?

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Occupational Therapy Yes

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

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Is there an enrollee Copayment?

No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required? No
Is a referral required for Physician Specialist Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee N

No

Out-of-Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Mental Health
Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

No

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 6

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No
SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Podiatrist Services? Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required? Yes

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Is a referral required for Other Health Care

Professional Services?

Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Psychiatric Services? Yes **SECTION B: #7I PT AND SP SERVICES - BASE 1**

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required? Yes Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit

for Part B services?

Select the Medicare-covered benefits that may

have Additional Telehealth Benefits available:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth

Services?

Notes: ADDITIONAL TELEHEALTH SERVICES

> COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY

: 7d: Physician Specialist Services

CLINICS.

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

No

Yes

No

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Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Opioid Treatment No

Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

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Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient Substance Yes

Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood No

Services as a supplemental benefit under Part

C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Select enhanced benefit:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Select Type of Transportation for Plan

Yes

One-way

Yes

Approved Health-related Location:

Select Mode of Transportation for Plan : Taxi

Approved Health-related Location: : Rideshare Services

: Bus/Subway

: Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for No

Durable Medical Equipment (DME)?

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Is authorization required?

Yes

Notes:

DME Supplies 0%, Wheelchair 0%, DME Hosp

Bed 10%, DME Power Wheelchair 0%, All

other DME 0%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? Yes

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

20%

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

20%

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

20%

20%

Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?

Nο

Is there an enrollee Copayment?

No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?

Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?

No

Do you limit Diabetic Supplies and Services to

No

those from specified manufacturers?

Yes

Is authorization required? **SECTION B: #12 DIALYSIS SERVICES - BASE 1**

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment? SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Yes

Is a referral required for Dialysis Services?

No

SECTION B: #13A ACUPUNCTURE - BASE 1

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Does the plan provide Acupuncture as a supplemental benefit under Part C?

Yes

Select enhanced benefit:

: Number of Treatments

Select type of benefit for Number of

Mandatory

Treatments:

Is this benefit unlimited for Number of

No

Treatments?

Indicate limit for Number of Treatments:

6

Indicate Number of Treatments periodicity:

Every year

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

500.00

amount:

Select Maximum Plan Benefit Coverage

Every year

periodicity:

No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Acupuncture?

Yes

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Yes

Select type of benefit for OTC Items:

Mandatory

Yes

Is there a service-specific Maximum Plan

Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage

amount:

60.00

Select Maximum Plan Benefit Coverage

periodicity:

Every three months

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

No

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Yes

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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Attestation:

off

Is there an enrollee Deductible? Is there an enrollee Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

No

No No

THE FOLLOWING CATEGORIES ARE COVERED:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE

(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.

7) FIBER SUPPLEMENTS

8) TOPICAL SUNSCREEN

9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.



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Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C?

Yes

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Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

Select type of benefit for Meals:

Select the type of primarily health related meals

benefit offered:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

hospitilization No

Mandatory

No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for the Meal Benefit?

Yes

Is a referral required for the Meal Benefit?

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:

POST DISCHARGE

2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX

: Immediately following surgery or inpatient

PER YEAR.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? Yes
Is a referral required? No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical

Exam as a supplemental benefit under Part C?

No

Yes

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

: 14c3: Additional Sessions of Smoking and

Tobacco Cessation Counseling

: 14c4: Fitness Benefit*

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

Hotline)*

: 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*



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Select type of benefit for Health Education: Mandatory Select type of benefit for Nutritional/Dietary Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

6

9

Mandatory

Mandatory

: Nursing Hotline

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit: Both Sessions (Individual and Group)

Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:

Indicate number of visits offered in addition to

Medicare:

Select type of benefit for Fitness Benefit: Mandatory

Indicate type of Fitness Benefit offered (Select : Physical Fitness : Memory Fitness 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):

Select type of benefit for Home and Bathroom Mandatory

Safety Devices and Modifications:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Select which Other Defined Supplemental : 14c4: Fitness Benefit

Benefits have a Maximum Plan Benefit 114c8: Home and Bathroom Safety Devices and RACIONOR

60.00

Coverage amount (Select all that apply): Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

Every three months

Select Maximum Plan Benefit Coverage

periodicity for Fitness Benefit:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage 60.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage Every three months

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wh

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Indicate Maximum Plan Benefit Coverage

60.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Every three months

periodicity for Alternative Therapies:

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required? No
Is a referral required for Other Defined No

Supplemental Benefits?

Health Education Notes: THE HEALTH EDUCATION PROGRAM

DEVELOPS AND IMPLEMENTS

EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE

THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES,

PROMOTION OF HEALTHY LIFESTYLE

AND PREVENTION OF

COMPLICATIONS.IMPLEMENT AND

CARRY OUT EDUCATIONAL

STRATEGIES, EVALUATE THE RESULTS

AND CREATE FUTURE

GOALS.INTERVENTIONS MIGHT

INCLUDE: EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO

IMPROVE THE MEMBER'S SKILL

SETS.THE HEP HAS ALSO INDIVIDUAL



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Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

Fitness Benefit Notes:*



INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A **QUIT DATE, REDUCE QUANTITY OF** CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

THE FOLLOWING ITEMS WILL BE COVERED:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE

EMR

off

THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes: THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE **EDUCATION REGARDING THE** SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS. THE FOLLOWING ITEMS WILL BE COVERED:

Home and Bathroom Safety Devices and Modifications Notes:*



1) MEDICAL BATHMAT

- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THIS IS A COMBINED BENEFIT WITH A

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> SINGLE, SHARED MAXIMUM BENEFI AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS.

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance? SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Kidney Disease No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment? No

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POSD:

Is authorization required for Medicare-covered

Glaucoma Screening?

Yes

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Yes

Is authorization required for Medicare-covered

Barium Enemas?

Yes

Is authorization required for Medicare-covered

Yes

Digital Rectal Exams?

Is authorization required for Medicare-covered

Yes

EKG following Welcome Visit?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

: Part B to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

drugs as part of a bundled service as a

No

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C? Yes

Select enhanced benefits:

: Restorative Services

: Prosthodontics, Other Oral/Maxilloracials 9

Surgery, Other Services

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

No, indicate number

Services?

Indicate number of visits for Restorative

1

Services:

Select the Restorative Services periodicity:

Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other

Mandatory

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Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Indicate number of visits for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services:

Select the Prosthodontics/Other

Oral/Maxillofacial Surgery/Other Services

periodicity:

Other, Describe

No, indicate number

Yes

1

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Plan-specified amount per period

3000.00

Every year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

Restorative Services Notes:

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24

MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER

TOOTH. SINGLE CROWNS REQUIRE PRE

AUTHORIZATION.

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services Notes:

PROSTHODONTIC SERVICES:

REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE,

COVERED EVERY 5 YEARS. DENTURE

REPAIR SERVICES, INCLUDING

SERVICES RELATED TO THE REPAIR OF

EXISTING COMPLETE OR PARTIAL

DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES

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(SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS. SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL). ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

SMR

No

No



SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

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SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses: Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	STRACTONOR
Is there an enrollee Deductible?	No No Contrato Número
Is there an enrollee Copayment?	No R contrato Num
SECTION B: #17B EYEWEAR - BASE 6	2.3

Yes

No

No

supplemental benefit under Part C?

Does the plan provide Hearing Exams as a

SECTION B: #18A HEARING EXAMS - BASE 1

Is a referral required for Eyewear?

Select enhanced benefits:

Is authorization required?

: Fitting/Evaluation for Hearing Aid

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Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

1

Mandatory

No, indicate number

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all Mandatory

types):

Is this benefit unlimited for Hearing Aids (all

types)?

Yes

Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select enhanced benefits:

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

Both ears combined

Plan-specified amount per period

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage 600.00

amount:

Indicate Maximum Plan Benefit Coverage Every three years

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

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Is there an enrollee Copayment? No
Is there an enrollee Deductible? No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required? Yes
Is a referral required for Hearing Aids? No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

the Chronically Ill?

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the Yes

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status

: Medicare Advantage Rewards and Incentives

Programs

No

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Annual Wellness Visit

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or

morej.

: Telephonic : In-Person

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

Type of Part C Reward or Incentive: : Gift Card

: Item : Other

Yes

Reward or Incentive Notes: LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN

CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD

AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s) 20.00

Frequency of Reward or Incentive Eligibility: Other, Describe

requestion of the man of measure Englishing.

Other Description: AVAILABLE TO REEDEEM INSTANTLY

OR ACCUMULATE FOR FUTURE

REDEMPTION. ONLY AVAILABLE FOR

ENROLLEES IN RI COMPONENT.





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No

who

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

1549

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and

Incentives are you offering?

Type of Part C Reward or Incentive: : Gift Card

: Item : Other

Part C Reward or Incentive Notes: LIMITED PURPOSE CARD. USAGE WILL

BE RESTRICTED TO CERTAIN

CATEGORIES IN SPECIFIC

MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE

Part C Reward or Incentive amount(s): 130.00

Frequency of Reward or Incentive Eligibility: Other, Describe

Other Description: PARTICIPATING ENROLLEES CAN

REDEEM REWARDS INSTANTLY, OR CAN

OPT TO ACCUMULATE EARNED FUNDS

FOR FUTURE REDEMPTION.

Eligibility Criteria: BENEFICIARIES WITH A QUALIFYING

CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE

MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND

INCENTIVES: APPLICABLE TO

CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS).

CONCERNING THE DIABETES

DIAGNOSIS, ONLY THE CRITERION OF

POLYPHARMACY WILL APPLY.

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ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING

DIALYSIS), ALZHEIMER'S (SEVERE OR

LATE STAGE), ACTIVE CANCER

(RECEIVING

CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.

Maximum Annual Part C Rewards and

Incentives Available:

150.00

Yes

1

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

How many packages does your 19a Reduction

in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA

VBID

Uniformity Flexibility or SSBCI?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 22313 Expected Number of Enrollees to be engaged 22313

and receive Model benefits:

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE

No

No

INFO): PACKAGE #1

Is there a prerequisite for reduction of cost

sharing for this package?

Does the plan reduce cost sharing to \$0 for all

covered benefits, up to a maximum aggregate

amount?

Select the benefits that apply to reduced cost

sharing:

Select the Medicare-covered benefits that will

receive reduced cost sharing:

: Medicare-covered benefits

: 11a: Durable Medical Equipment (DME)

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: 11b1: Prosthetic Devices

: 11b2: Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2

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(OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?

Yes

Select the types of benefits that apply to the

Select the Medicare-covered benefits that will

: Medicare-covered benefits

coinsurance cost sharing:

: 11a: Durable Medical Equipment (DME)

receive reduced coinsurance:

: 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 5 (REDUCED COINSURANCE): PACKAGE #1

Indicate Minimum Coinsurance Percentage for

0%

Durable Medical Equipment (DME)

Indicate Maximum Coinsurance Percentage for

0%

Durable Medical Equipment (DME)

Indicate Minimum Coinsurance Percentage for

0%

Prosthetic Devices

Indicate Maximum Coinsurance Percentage for

0%

Prosthetic Devices

Indicate Minimum Coinsurance Percentage for

0%

Medical Supplies

Indicate Maximum Coinsurance Percentage for

0%

Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?

No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a maximum aggregate amount of

Yes

reduced cost sharing?

Specify the maximum aggregate amount of

200.00

reduced cost sharing:

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND

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19B.

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or

: Socioeconomic Status

both:

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 22313 Expected Number of Enrollees to be engaged 22313

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE **INFO): PACKAGE #1**

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13b: Over-the-Counter (OTC) Items

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

: 13i-O: Non-Primarily Health Related Benefits

for the Chronically Ill (Other)

: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage Yes

amount?

200.00

Specify the maximum benefit amount:

Every month

Select the package level maximum coverage periodicity:

: 13b: Over-the-Counter (OTC) Items

Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:

: 13i1: Food and Produce

: 13i2: Meals (beyond limited basis)

: 13i3: Pest Control

: 13i6: Social Needs Benefit

: 13i10: General Supports for Living

: 13i-O1: Other 1 Non-Primarily Health Related

wh

Benefit

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B. SUCH AS:

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.



Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Yes

Mandatory

Yes



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Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

Select Maximum Plan Benefit Coverage

periodicity:

Does your Maximum Plan Benefit Coverage

amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

200.00

Every month

No

No

Yes

No

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D

OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed

Care Manual?

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:

1) MINERALS AND VITAMINS

2) FIRST AID SUPPLIES

3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS

THAT ALLEVIATE SYMPTOMS

4) MOUTH CARE

5) INCONTINENCE SUPPLIES (ADULT

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING

SPECIFICALLY MONITOR BLOOD

PRESSURE (FOR MEMBERS WHO MEET

MEDICAL CRITERIA FOR ON-GOING

MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD

PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE

MEDICAL EVALUATION AND/OR

PREAUTHORIZATION.

- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING,

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BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)
12) PERSONAL HYGIENE PRODUCTS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically III

includes:

: Food and Produce

: Meals (beyond limited basis)

: Pest Control

: Social Needs Benefit

: General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

Yes

Indicate Maximum Plan Benefit Coverage

amount:

200.00

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Food and Produce?

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: MONTHLY ALLOWANCE.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1:

PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?

Select type of benefit for Meals (beyond limited

basis):

Is the meal benefit unlimited?

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

Yes

Mandatory

Yes

Yes

200.00



amount:

Select Maximum Plan Benefit Coverage

Every month

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for the Meals (beyond

No

limited basis)?

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE

COVERING PREPARED FOOD.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a

Yes

supplemental benefit under Part C?

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

200.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Every month

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAG

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Pest Control? No SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE **COVERING ITEMS SUCH AS: CLEANING**

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PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a

Select type of benefit for Social Needs Benefit:

supplemental benefit under Part C?

Mandatory

Is there a service-specific Maximum Plan

Yes

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Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Social Needs Benefit? No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

> COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL

GROOMING SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #1

Does the plan provide General Supports for Yes

Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for Mandatory

Living:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No

Is a referral required for General Supports for No

Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3:

PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING GASOLINE, UTILITIES, HOME

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APPLIANCES, TOWELS / LINENS AND CLOTHING, HARDWARE ITEMS.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your NonPrimarily Health Related Benefits for the
Chronically Ill includes:
: Other 2
: Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service: PET CARE
Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Other 1 Services?

No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes: UNDER THIS CATEGORY WE WILL BE

COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS,

GROOMING ITEMS AND SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH REL BENEFIT - BASE 1: PACKAGE #1

Enter name of Service: PERSONAL CARE ITEMS

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 200.00

amount:

Select Maximum Plan Benefit Coverage Every month

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED

BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Other 2 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:

UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 1: PACKAGE #1**

Enter name of Service:

ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER

Select type of benefit for Other 3:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

300.00

amount:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 2: PACKAGE #1**

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? Is authorization required? No Is a referral required for Other 3 Services? No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED **BENEFIT - BASE 3: PACKAGE #1**

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY SMIR

REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS*

3. PEST CONTROL (1 PER QTR.)

4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED



LIGHTING, TRACTION / ANTI-SLIP TAPE.
GRIP AND SAFETY BARS COULD ALSO
BE INSTALLED IF THE MEMBER
PROVIDES THEM. (1 VISIT PER YR.)
5. TECHNOLOGY CONNECTIVITY
SERVICES (1 IN-PERSON VISIT AND
UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF \$300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE \$200 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSITANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and

Modifications*

: 14c17: Alternative Therapies*

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select

all that apply):

Mandatory

: Physical Fitness : Memory Fitness

Select type of benefit for Home and Bathroom

Safety Devices and Modifications:

Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS BASE 2: PACKAGE #1

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

Yes

Therapies?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

Yes

Select which Other Defined Supplemental

Benefits have a Maximum Plan Benefit

Coverage amount (Select all that apply):

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

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Modifications

: 14c17: Alternative Therapies

Indicate Maximum Plan Benefit Coverage

amount for Fitness Benefit:

200.00

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Select Maximum Plan Benefit Coverage

Monthly

periodicity for Fitness Benefit:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 5: PACKAGE #1**

Indicate Maximum Plan Benefit Coverage

200.00

amount for Home and Bathroom Safety Devices

and Modifications:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Home and Bathroom Safety

Devices and Modifications:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 6: PACKAGE #1**

Indicate Maximum Plan Benefit Coverage

200.00

amount for Alternative Therapies:

Select Maximum Plan Benefit Coverage

Other, Describe

periodicity for Alternative Therapies:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 7: PACKAGE #1**

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 12: PACKAGE #1**

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 14: PACKAGE #1**

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Fitness Benefit Notes:*

BE COVERED:

1) PHYSICAL EXERCISE PEDALS

ITEMS SUCH AS THE FOLLOWING WILL

- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 15: PACKAGE #1**

Home and Bathroom Safety Devices and

MONTHLY ALLOWANCE.

Modifications Notes:*

ITEMS SUCH AS THE FOLLOWING WILL

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BE COVERED:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*

MONTHLY ALLOWANCE.

UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL

MEDICINE ITEMS.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

(Select all that apply):

: Diabetes

Expected Number of Enrollees to be Targeted:

1549

Expected Number of Enrollees to be engaged

320

and receive Model benefits:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage

No

amount?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

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NEW AND INNOVATIVE TECHNOLOGIES Notes:

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional):

NEW AND INNOVATIVE TECHNOLOGIES

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Other Services? Yes

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes:

THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED FOR DETECTING TRENDS AND TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? Yes Indicate the Minimum Coinsurance percentage 5% for Medicare covered Benefits for prescription drugs and biologics:

5%

Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:

5

Indicate the maximum per drug amount Is there an enrollee Copayment?

No Yes

Is there an enrollee Coinsurance? Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care

5%

day: Indicate the Maximum Coinsurance percentage

5%

for Medicare covered Benefits for a respite care day:

Indicate the maximum per day amount **SECTION B: #19C VBID HOSPICE- BASE 2** 5

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Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out- of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-	Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? Yes
How many groups of Reductions in Cost 1

of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Sharing are you offering?

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 1

Select the benefits that apply to the Reductions : Medicare-covered benefits

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in Cost Sharing benefit:

Select which Medicare-Covered Services your

Reductions in Cost Sharing apply to:

: 11a: Durable Medical Equipment (DME)

: 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 2

Indicate Max Plan Benefit amount:

Select Reductions in Cost Sharing periodicity:

Can the reduction in cost sharing be applied to a

deductible?

What is your Reductions in Cost Sharing mode

of delivery?

No

200.00

: Debit Card

Every month

Notes: MONTHLY ALLOWANCE IN THE FORM

OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED

SERVICES IN THE COMBINED PACKAGE.
MEMBER IS RESPONSIBLE FOR COSTS
THAT EXCEED THE ALLOWANCE.

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

Select the number of Combined Supplemental

Benefit packages you are offering?

2

Yes

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are

included in your Combined Supplemental

Benefit package:

: 13b: Over-the-Counter (OTC) Items

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: 14c17: Alternative Therapies

What is your combined supplemental benefits

mode of delivery?

Other Description:

: Other

MEMBER WILL BE ABLE TO USE THE

COMBINED ALLOWANCE TO PURCHASE

ITEMS FROM A CATALOG.

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: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are

Yes

No

60.00

Every three months

No

: 13b: Over-the-Counter (OTC) Items

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included in your Combined Supplemental Benefit package:

: 14c4: Fitness Benefit

: 14c8: Home and Bathroom Safety Devices and

Modifications

: Debit Card

: 14c17: Alternative Therapies

: 19b: Additional Benefits for VBID/UF/SSBCI

What is your combined supplemental benefits mode of delivery?

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:

No

Yes

200.00 Every month

No

COMBINED BENEFITS #1: THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:

- 1) MINERALS AND VITAMINS
- 2) FIRST AID SUPPLIES
- 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
- 4) MOUTH CARE
- 5) INCONTINENCE SUPPLIES (ADULT

DIAPERS & UNDER PADS)

6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE

PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR

PREAUTHORIZATION.

- 7) FIBER SUPPLEMENTS
- 8) TOPICAL SUNSCREEN
- 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED

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FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:

- 1) MEDICAL BATHMAT
- 2) RAISED TOILET SEAT
- 3) HANDHELD SHOWER HEAD
- 4) REACHER
- 5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:

- 1) PHYSICAL EXERCISE PEDALS
- 2) STRETCH STRAPS
- 3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

COMBINED BENEFITS #2:
MONTHLY ALLOWANCE IN THE FORM
OF A DEBIT CARD. THE DEBIT CARD
ALLOWS THE MEMBER TO ACCESS
ADDITIONAL PRIMARILY HEALTH AND
NON-PRIMARILY HEALTH RELATED
SUPPLEMENTAL BENEFITS, SUCH AS.

- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS

Notes:



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- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)

- HOME AND BATHROOM SAFETY DEVICES

- PET CARE

- PERSONAL CARE ITEMS

- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES

- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

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):

Yes

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?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available with an extended day supply?

: Standard Retail Cost Sharing - 1 month Supply

: Standard Retail Cost Sharing - 3 month Supply 30

90

: Out-of-Network Pharmacy - one month supply

30

: Standard Mail-Order - 3-month supply

90

: Long-Term Care Pharmacy - 1-month supply

31

No

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Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?

No

off

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

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