

Appendix C (1)

Medicare Advantage Plan Benefit Package (PBP)

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2

NÚMERO DE CONTRATO

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

ADMINISTRACIÓN DE SEGUROS DE SALUD

H4004**048 MMM HEALTHCARE, LLC - Data Report****27 - 00002****Plan Characteristics**

NÚMERO DE CONTRATO

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
PMC Premier Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?

Not Available

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP:
No	No	None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?

No

Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan offer a standard bid for Visitor Travel Program V/T?

No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

yes

AEI

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

yes

AEI

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

Yes

AE

In Network (INN)**Services****Optional/Mandatory
/ Both**

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

yes
AE

Services	In Network (INN)	Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

was

A-E

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

yes
A-E

Services	In-Network
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services	In-Network
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	




Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services**In-Network**

Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral**Prior Authorization**

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AEI

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$200.00	Every Month		Completed

Yes

AEI

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

No Data Saved for Selected Section, Incomplete or Not Started.

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic back pain

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),

Yes
AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$85.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),

yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

5858

Expected number of chronically ill enrollees that will utilize SSBCI:

5539

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

yes

All

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Physical Fitness
Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

AEI *yes*

Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.			

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

AE1 Yes

Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.			

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
No	Referral required for this benefit?		
No	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.			
Prosthodontics, fixed (16c7) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.			
Oral and Maxillofacial Surgery (16c8) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Package ID	Package Name	Type of Package	Status
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.			
Eyeglasses (lenses and frames) (17b2) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.			
Upgrades (17b5) - Non-Medicare			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.			
Hearing Exams (18a) - Non-Medicare			
Is there a maximum plan benefit coverage?			



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

AEI

Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Yes

AE

Package ID	Package Name	Type of Package	Status
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS) LIMITED TO 2 EVENTS (1/SEMESTER) AND INDOOR AIR QUALITY EQUIPMENT SERVICES. ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Yes

Is there a deductible?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?



Package ID	Package Name	Type of Package	Status
No			
Notes			

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING

was
AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

yes

AEI

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Yes

AEI

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

AE1 Yes

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

yes
A/E

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

AEI was

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AEI

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Yes

AEI

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

AEI Yes

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

AEI Yes

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

ALL yes

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Yes
AE

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

AEI yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Prosthetics/Medical Supplies (11b) - Medicare

yes

AE

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

AEI *yes*

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

yes
AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No



Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

yes

AE

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

ALL *yes*

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

AEI *yes*

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Yes

AE

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

AE *yes*

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

yes
AE

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi

RideShare services

Bus/Subway

Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

yes

AE

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

AE1 was

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

Notes

AEI *Yes*

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

yes
AHL

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Yes

AEI

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

AE was

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes
AEI

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

AEI *was*

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS

AE *yes*

COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI *yes*

Yes

Referral required for this benefit?

No

Notes

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.

yes
AHL

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

AEI

Yes

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
A-E

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2500.00

Periodicity

Every 3 Years

yes

AEI

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

was
AEI

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

Yes

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

No

AEI

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Enter 3-month copayment

\$105.00

Coinsurance 1-month supply

25%

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-Network

Out-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%

yes

AEI

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

ADMINISTRACIÓN DE SEGUROS DE SALUD

H4003**27 - 0 0 0 0 2****058 MMM HEALTHCARE, LLC - Data Report**

NÚMERO DE CONTRATO

Plan Characteristics**General Information**

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Dorado Platino (HMO D-SNP)	Puerto Rico Northwest	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP:
No	No	None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?

No

Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan offer a standard bid for Visitor Travel Program V/T?

No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

Yes

AE

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	




Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

was

AE

In Network (INN)**Services****Optional/Mandatory
/ Both**

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

In Network (INN)

Services

Optional/Mandatory
/ Both

Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)

Services

Optional/Mandatory
/ Both

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

yes
A/E

Services**In-Network**

Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services**In-Network**

Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

yes
A-E

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services**In-Network**

Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral**Prior Authorization**

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AEI

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)

was
AEL

Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$35.00	Every 3 months		Completed

Yes
 A/E

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

No Data Saved for Selected Section, Incomplete or Not Started.

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic back pain

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$145.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),

was

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

3994

Expected number of chronically ill enrollees that will utilize SSBCI:

3817

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Physical Fitness
Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

AEI *was*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.			

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

yes
A-E

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI was

Package ID	Package Name	Type of Package	Status
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.			
Prosthodontics, fixed (16c7) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.			
Oral and Maxillofacial Surgery (16c8) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			

Package ID	Package Name	Type of Package	Status
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.			

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

AEI ^{was}

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

yes
A/E

Package ID**Package Name****Type of Package****Status**

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

yes

AEI

Package ID	Package Name	Type of Package	Status
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			

yes
A-E

Package ID	Package Name	Type of Package	Status
	ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.		

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

was
AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

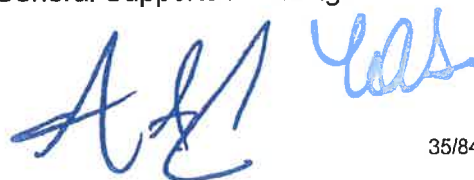
Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Yes

Is there a deductible?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?



Package ID	Package Name	Type of Package	Status
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.			
Other 3 (13i13) - Non-Medicare			
Service Name			
MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING			

Yes
A/E

Package ID	Package Name	Type of Package	Status
THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.			

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Yes

AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

yes

AEI

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

yes

AE

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Yes

AEI

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

yes
A/E

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Yes

ALL

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

yes
A-E

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

yes
A-E

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes

AE

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

yes

AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

AEI

yes

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

yes

AEI

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

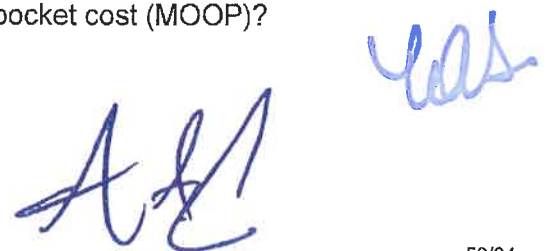
Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No



Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

yes

ALL

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

yes

AE

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

yes

AEI

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
A/E

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

yes

AEI

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

yes
A/E

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
A.S.

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

AEI *yes*

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

yes
AHL

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi

RideShare services

Bus/Subway

Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

yes

AEI

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

yes
A-E

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

Notes

Yes
AE

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Yes
AE

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

yes
A/E

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes
A/E

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$1500.00

yes

AEI

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS

yes
A/E

COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

yes
A/E

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes
A/E

Yes

Referral required for this benefit?

No

Notes

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.

yes
A/E

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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
A/E

Yes

Combined maximum amount

\$750.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
A-E

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2500.00

Periodicity

Every 3 Years

yes
A/E

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

yes

AEI

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

Yes

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

No

AEI

yes

AE

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Enter 3-month copayment

\$105.00

Coinsurance 1-month supply

25%

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-Network

Out-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%

Yes
A/E

yes
A-E

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR ADMINISTRACIÓN DE SEGUROS DE SALUD

H4004**27 - 00002**

068 MMM HEALTHCARE, LLC - Data Report

NÚMERO DE CONTRATO

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Combo Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP:
No	No	None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

was

AE

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

yes

A-E

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

In Network (INN)

Services

Optional/Mandatory
/ Both

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

yes

A-E

Services	In Network (INN)	
		Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)

Fluoride Treatment(16b5)

Other Preventive Dental Services(16b6)

Comprehensive Dental(16c)

Restorative Services(16c1)

Required

Mandatory

Endodontics(16c2)

Periodontics(16c3)

Prosthodontics, removable(16c4)

Required

Mandatory

Maxillofacial Prosthetics(16c5)

Implant Services(16c6)

Required

Mandatory

Prosthodontics, fixed(16c7)

Required

Mandatory

Oral and Maxillofacial Surgery(16c8)

Orthodontics(16c9)

Adjunctive General Services(16c10)

Required

Mandatory

Eye Exams/Eyewear(17)

Eye Exams(17a)

Routine Eye Exams(17a1)

Other Eye Exam Services(17a2)

Eyewear(17b)

Contact Lenses(17b1)

Required

Mandatory

Eyeglasses (lenses and frames)(17b2)

Required

Mandatory

Eyeglass lenses(17b3)

Eyeglass frames(17b4)

Upgrades(17b5)

Hearing Exams/Hearing Aids(18)

Hearing Exams(18a)

Routine Hearing Exams(18a1)

Fitting/Evaluation for Hearing Aid(18a2)

Prescription Hearing Aids(18b)

Prescription Hearing Aids (all types)(18b1)

Prescription Hearing Aids - Inner Ear(18b2)

*Yes**AEI*

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

Yes

Select the Medicare-covered benefits that have tiered cost sharing:

Medicare Dental Services(16a)

Does this plan have tiered cost sharing for Non-Medicare covered services?

Yes

Select the Non-Medicare-covered benefits that have tiered cost sharing:

Restorative Services(16c1)

Prosthodontics, removable(16c4)

Implant Services(16c6)

Prosthodontics, fixed(16c7)

Adjunctive General Services(16c10)

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services

In-Network

Inpatient Hospital Services(1)

Inpatient Hospital-Acute(1a)

Yes

Inpatient Hospital Psychiatric(1b)

Yes

Skilled Nursing Facility (SNF)(2)

Yes

Cardiac and Pulmonary Rehabilitation Services(3)

Cardiac Rehabilitation Services(3-1)

Yes

Intensive Cardiac Rehabilitation Services(3-2)

Yes

Pulmonary Rehabilitation Services(3-3)

Yes

SET for PAD Services(3-4)

Yes

Emergency/Urgently Needed Services(4)

Emergency Services(4a)

Yes

Urgently Needed Services(4b)

Yes

Partial Hospitalization/Intensive Outpatient Program Services(5)

Yes
A/E

Services**In-Network**

Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes

Services	In-Network
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes

Yes
A-E

Services**In-Network**

Other Medicare Part B Drugs(15-3)

Yes

Dental(16)

Medicare Dental Services(16a)

Yes

Eye Exams/Eyewear(17)

Eye Exams(17a)

Yes

Eyewear(17b)

Yes

Hearing Exams/Hearing Aids(18)

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

*was**AE*

Services**In-Network**

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Yes
Fitness Benefit(14c4)	Yes
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Yes
Home and Bathroom Safety Devices and Modifications(14c8)	Yes
Alternative Therapies(14c17)	Yes
Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes

Prior Authorization & Referral**Prior Authorization**

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)

Yes

AEI

Individual Sessions for Mental Health Specialty Services(7e1)
Group Sessions for Mental Health Specialty Services(7e2)
Podiatry Services(7f)
Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)



Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)
Hearing Exams(18a)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization Program(5a)
Intensive Outpatient Program Services(5b)
Chiropractic Services(7b)
Routine Chiropractic Care(7b1)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Group Sessions for Mental Health Specialty Services(7e2)
Podiatry Services(7f)
Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Acupuncture Treatments(13a)
Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Yes
A-E

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$45.00	Every 3 months		Completed

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic back pain

Prerequisite for reduction of cost sharing for this package?

No

Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount?

No

Select the Medicare benefits that apply to reduced cost sharing

Package ID	Package Name	Type of Package	Status
	Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2), Medicare Dental Services (16a) Select the Non-Medicare benefits that apply to reduced cost sharing Restorative Services (16c1), Prosthodontics, removable (16c4), Implant Services (16c6), Prosthodontics, fixed (16c7), Adjunctive General Services (16c10) Are any benefits exempt from the plan-level deductible? No Is there a maximum aggregated amount of reduced cost sharing? Yes Specify the maximum aggregated amount of reduced cost sharing: \$120.00 Indicate mode of delivery for maximum coverage amount Debit Card Expected number of chronically ill enrollees eligible for SSBCI: 11893 Expected number of chronically ill enrollees that will utilize SSBCI: 11370 Notes ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.		

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

	Medical Supplies (11b2) - Medicare		
--	------------------------------------	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Medicare Dental Services (16a) - Medicare		
--	---	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Restorative Services (16c1) - Non-Medicare		
--	--	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Prosthodontics, removable (16c4) - Non-Medicare		
--	---	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Implant Services (16c6) - Non-Medicare		
--	--	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Prosthodontics, fixed (16c7) - Non-Medicare		
--	---	--	--

	Min: 0% Max: 0%,		
--	------------------	--	--

	Adjunctive General Services (16c10) - Non-Medicare		
--	--	--	--

	Min: 0% Max: 0%		
--	-----------------	--	--

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

No

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),

Autoimmune disorders,

Cancer,

Cardiovascular disorders,

Chronic heart failure,

Dementia,

Diabetes mellitus,

Overweight, obesity, and metabolic syndrome,

Chronic gastrointestinal disease,

Chronic kidney disease (CKD),

Package ID	Package Name	Type of Package	Status
	Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description		
	Chronic Hypertension		
	Other 2 Description		
	Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description		
	Osteoporosis		
	Other 4 Description		
	Chronic back pain		
	Prerequisite for any additional benefits for this package?		
	No		
	Select all the Non-Medicare-covered additional benefits offered in this package		
	Over-the-Counter (OTC) Items (13b), Food and Produce (13i1), Meals (beyond limited basis) (13i2), Pest Control (13i3), Social Needs Benefit (13i6), General Supports for Living (13i10), Other 1 (13i11), Other 3 (13i13), Fitness Benefit (14c4), Home and Bathroom Safety Devices and Modifications (14c8), Oral Exams (16b1), Dental X-Rays (16b2), Other Diagnostic Dental Services (16b3), Restorative Services (16c1), Endodontics (16c2), Periodontics (16c3), Prosthodontics, removable (16c4), Implant Services (16c6),		



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$120.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),

Yes
AE

Package ID	Package Name	Type of Package	Status
	Eyeglasses (lenses and frames) (17b2), Upgrades (17b5), Fitting/Evaluation for Hearing Aid (18a2), Prescription Hearing Aids (all types) (18b1)		
	Expected number of chronically ill enrollees eligible for SSBCI: 11893		
	Expected number of chronically ill enrollees that will utilize SSBCI: 11370		

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Yes

Coinsurance percentage

0%

Is there a copayment?

Yes

Copayment amount

yes

A-E

Package ID	Package Name	Type of Package	Status
\$0.00			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.			
Endodontics (16c2) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.			
Periodontics (16c3) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			

yes

AE

Package ID	Package Name	Type of Package	Status
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.			
Prosthodontics, removable (16c4) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
Yes			
Coinsurance percentage			
0%			
Is there a copayment?			
Yes			
Copayment amount			
\$0.00			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.			
Implant Services (16c6) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
Yes			
Coinsurance percentage			
0%			
Is there a copayment?			
Yes			
Copayment amount			

Handwritten signatures: "AEL" and "yes" in blue ink.

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

\$0.00

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Yes

Coinsurance percentage

0%

Is there a copayment?

Yes

Copayment amount

\$0.00

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Yes

Coinsurance percentage

0%

Is there a copayment?

Yes

Copayment amount

\$0.00

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

yes

AE

Package ID	Package Name	Type of Package	Status
No			
Referral required for this benefit?			

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (1315) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13111) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Yes

AEL

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

yes

A-E

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Yes

AE

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

AEI

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

yes

AE

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Yes

AE

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Yes

AEI

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes
A-E

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

yes
A-E

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED
IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Yes

AEI

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI *yes*

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

yes
A-E

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AE1 yes

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

AE *yes*

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

yes

AE

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Yes

AE

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

AE

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes
AEI

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

yes

AEI

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

AEI

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

20%

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes
AE

No

Notes

MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

Yes
A-E

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

yes
A/E

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Periodicity

Every Year

Type of transportation

One-Way

Yes
A/E

Select Mode of Transportation

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS
PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED
LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

*Yes**AE*

No

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

yes
A-E

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered (Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

yes
A-E

Yes

Referral required for this benefit?

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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

Yes

AEI

INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Yes

AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
AE

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Yes

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

AEI

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

yes
A/E

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISIT.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$1000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

Yes with a min & max

yes

AE

Minimum coinsurance Maximum coinsurance

0% 20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance Maximum coinsurance

0% 20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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. MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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

Yes
A/E

PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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. MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN. MINIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS. SERVICES MAY VARY BY CLINIC. MAXIMUM COINSURANCE APPLIES FOR SERVICES PROVIDED AT ALL OTHER FACILITIES.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

AEI

Yes

Combined maximum amount

\$1000.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes

AEI

Rx**Rx Characteristics**

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply**Standard Retail**

Select days for 1-month supply

30

Select days for 3-month supply

90

Yes

AE

Standard Mail-Order

Select days for 3-month supply

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

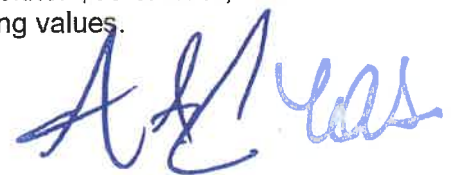
Standard Retail

Enter 1-month copayment

\$35.00

Enter 3-month copayment

\$105.00



Coinsurance 1-month supply
25%

Standard Mail-Order

Coinsurance 3-month supply
25%

Enter 3-month copayment
\$105.00

Coinsurance 3-month supply
25%

Long-Term Care

Enter 1-month copayment
\$35.00

Long-Term Care Coinsurance
25%

Out-of-Network

Out-of-network 1-month
copayment
\$35.00

Out-of-Network Coinsurance
25%

yes
AE

was

AE

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

ADMINISTRACIÓN DE SEGUROS DE SALUD

H4004**072 - 1 MMM HEALTHCARE, LLC - Data Report****27 - 0 0 0 0 2****Plan Characteristics**

NÚMERO DE CONTRATO

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Relax Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP: None of the above (i.e., no buy-down applied)
No	No	

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?

No

Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan offer a standard bid for Visitor Travel Program V/T?

No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

yes

AE

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

yes

AE

In Network (INN)

Services

Optional/Mandatory
/ Both

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

Services	In Network (INN)		Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required		Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required		Mandatory
Fitness Benefit(14c4)	Required		Mandatory
Enhanced Disease Management(14c5)			
Telemonitoring Services(14c6)			
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required		Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required		Mandatory
Counseling Services(14c9)			
In-Home Safety Assessment(14c10)			
Personal Emergency Response System (PERS)(14c11)			
Medical Nutrition Therapy (MNT)(14c12)			
Post discharge In-Home Medication Reconciliation(14c13)			
Re-admission Prevention(14c14)			
Wigs for Hair Loss Related to Chemotherapy(14c15)			
Weight Management Programs(14c16)			
Alternative Therapies(14c17)	Required		Mandatory
Therapeutic Massage(14c18)			
Adult Day Health Services(14c19)			
Home-Based Palliative Care(14c20)			
In-Home Support Services(14c21)			
Support for Caregivers of Enrollees(14c22)			
Home infusion bundled services(15)			
Dental(16)			
Diagnostic and Preventive Dental(16b)			
Oral Exams(16b1)			
Dental X-Rays(16b2)			
Other Diagnostic Dental Services(16b3)			

was

A-E

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

*yes**AEI*

\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Yes

AEI

Services**In-Network**

Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services**In-Network**

Ambulance Services(10a)	.
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

Yes

A-E

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan.Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services**In-Network**

Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral**Prior Authorization**

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

- Inpatient Hospital-Acute(1a)
- Inpatient Hospital Psychiatric(1b)
- Skilled Nursing Facility (SNF)(2)
- Cardiac Rehabilitation Services(3-1)
- Intensive Cardiac Rehabilitation Services(3-2)
- Pulmonary Rehabilitation Services(3-3)
- SET for PAD Services(3-4)
- Partial Hospitalization Program(5a)
- Intensive Outpatient Program Services(5b)
- Home Health Services(6)
- Chiropractic Services(7b)
- Routine Chiropractic Care(7b1)
- Occupational Therapy Services(7c)
- Physician Specialist Services(7d)
- Individual Sessions for Mental Health Specialty Services(7e1)
- Group Sessions for Mental Health Specialty Services(7e2)
- Podiatry Services(7f)

Yes

AEI

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$60.00	Every 3 months		Completed

Yes

AEI

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically Ill?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed

Chronic Conditions - Please choose one or more

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description		
	Chronic Hypertension		
	Other 2 Description		
	Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description		
	Osteoporosis		
	Other 4 Description		
	Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package?		
	No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount?		
	No		
	Select the Medicare benefits that apply to reduced cost sharing		
	Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		

Yes

AE

Package ID	Package Name	Type of Package	Status
Are any benefits exempt from the plan-level deductible?			
No			
Is there a maximum aggregated amount of reduced cost sharing?			
Yes			
Specify the maximum aggregated amount of reduced cost sharing:			
\$210.00			
Indicate mode of delivery for maximum coverage amount			
Debit Card			
Expected number of chronically ill enrollees eligible for SSBCI:			
6147			
Expected number of chronically ill enrollees that will utilize SSBCI:			
5888			
Notes			
ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.			

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Medical Supplies (11b2) - Medicare

Min: 0% Max: 0%

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

Yes

AEI

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

yes

AEI

Package ID**Package Name****Type of Package****Status**

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$210.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

6147

Expected number of chronically ill enrollees that will utilize SSBCI:

5888

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Package ID**Package Name****Type of Package****Status**

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Yes

AL

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

AEI *yes*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

was
A/E

Package ID	Package Name	Type of Package	Status
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.			

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

AEI

yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AEI

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

yes

AEI

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

yes

AEI

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

yes
A-E

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

AEI

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

yes
A-E

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Yes
AE

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
A-E

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
A-E

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

yes
A-E

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes

AEI

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

yes

AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

yes

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%



Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE FOR DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

AEI cas

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No



Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

yes
A-E

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Yes
A/E

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

was
A/E

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI

yes

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Yes
A/E

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

AEI *yes*

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Yes
A/E

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

AEI *was*

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Yes
AEI

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI *yes*

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes
A/E

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Yes

AE

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Yes
A/E

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes



ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
A/E

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AEI Yes

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

Yes
A/E

Medicare-defined Part D
Deductible amount
\$700.00

Medicare-defined Part D
Coinsurance amount
25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold
\$2400.00

Cap for one-month supply of
each Part D-covered insulin
\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

AEI *Yes*

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-NetworkOut-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%

yes
A-E

was

AE

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

H4004

ADMINISTRACIÓN DE SEGUROS DE SALUD

072 - 2 MMM HEALTHCARE, LLC - Data Report

27 - 0 0 0 0 2

Plan Characteristics

General Information

NÚMERO DE CONTRATO

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Relax Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP:
No	No	None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?

No

Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan offer a standard bid for Visitor Travel Program V/T?

No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

Yes

AE

Services	In Network (INN)
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Required
Intensive Outpatient Program Services(5b)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	

yes

AEI

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

Yes
AEI

In Network (INN)

Services	Optional/Mandatory / Both	
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

In Network (INN)

Services		Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

In Network (INN)

Services

Optional/Mandatory
/ Both

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

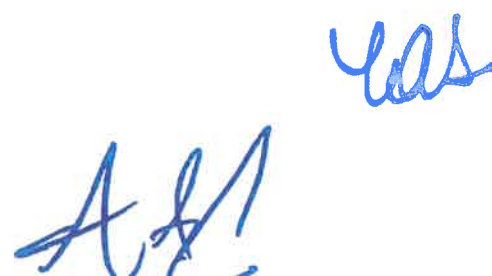
Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount



\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Yes

AEI

Services	In-Network
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services	In-Network
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

Yes

AE

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services	In-Network
Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AEI

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$20.00	Every 3 months		Completed

Yes

AE

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed
Chronic Conditions - Please choose one or more			

Yes

AE

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description		
	Chronic Hypertension		
	Other 2 Description		
	Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description		
	Osteoporosis		
	Other 4 Description		
	Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package?		
	No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount?		
	No		
	Select the Medicare benefits that apply to reduced cost sharing		
	Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Are any benefits exempt from the plan-level deductible?

No

Is there a maximum aggregated amount of reduced cost sharing?

Yes

Specify the maximum aggregated amount of reduced cost sharing:

\$95.00

Indicate mode of delivery for maximum coverage amount

Debit Card

Expected number of chronically ill enrollees eligible for SSBCI:

19635

Expected number of chronically ill enrollees that will utilize SSBCI:

18809

Notes

ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Medical Supplies (11b2) - Medicare

Min: 0% Max: 0%

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

Yes

AEI

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

Yes
AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$95.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

19635

Expected number of chronically ill enrollees that will utilize SSBCI:

18809

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

AE

Package ID	Package Name	Type of Package	Status
Yes			
The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.			
true			
Are you offering Naloxone coverage as a Part C OTC benefit?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?			
No			
Mode of delivery for the OTC Items			
Debit Card			
Catalogue Purchase			
Authorization required for this benefit?			
No			
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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.			
Other Defined Supplemental Benefits (14c) - Non-Medicare			
Is there a deductible?			

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Yes
A/E

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Yes
A-E

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

AEI was

Package ID	Package Name	Type of Package	Status
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
	ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.		
	Eyeglasses (lenses and frames) (17b2) - Non-Medicare		
	Is this benefit unlimited?		
Yes	Is there a coinsurance?		
No	Is there a copayment?		
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
	ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.		
	Upgrades (17b5) - Non-Medicare		
	Is there a coinsurance?		
No	Is there a copayment?		
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		

Yes

AEI

Package ID	Package Name	Type of Package	Status
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.			

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

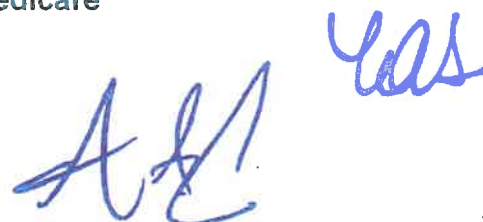
No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
No	Is there a copayment?	No	Authorization required for this benefit?
No	Referral required for this benefit?	No	Notes
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.			

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

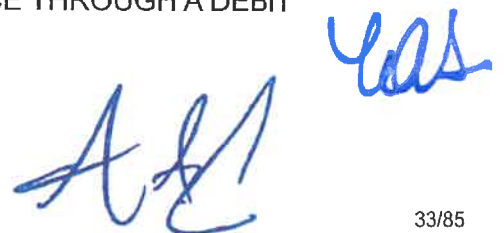
No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?



Package ID	Package Name	Type of Package	Status
Yes			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			
Pest Control (13i3) - Non-Medicare			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13111) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

A-E

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AE

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

Yes

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

AEI was

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

AE

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

Yes

AEI

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Yes

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

AE

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Handwritten signature: A. E. [unclear] Yes

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No



Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Yes

AE

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI *yes*

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Yes

Yes

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Yes
AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%

Yes

AEI

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

AEI

Yes

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Yes

AEI

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

yes

AEI

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
A-E

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

AE

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

AE1 *yes*

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

yes
AE

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

AEI was

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AE

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

AEI Yes

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

yes

AE

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No



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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

yes
A/E

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

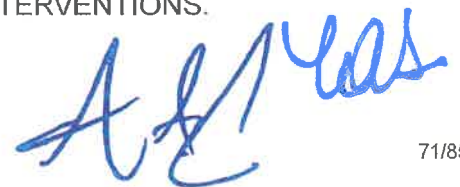
Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare



Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes
AE

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Yes

AEI

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

yes

Comprehensive Dental (16c) - Non-Medicare

AEI

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes
A-E

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

yes
A-E

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes



ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
A-E

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AEI Yes

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

AEI *yes*

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-Network

Out-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%

A handwritten signature in blue ink, appearing to be 'A. E. Cas'.

yes
AEL

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

H4004

072 - 3 MMM HEALTHCARE, LLC - Data Report

ADMINISTRACIÓN DE SEGUROS DE SALUD

Plan Characteristics

27 - 0 0 0 0 2

General Information

Organization Legal Name	Organization Marketing Name	Organization Type	NÚMERO DE CONTRATO
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP	
Plan Name	Plan Geographic Name		
MMM Relax Platino (HMO D-SNP)	Puerto Rico		

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP:
No	No	None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

yes

AEI

Services	In Network (INN)
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Required
Intensive Outpatient Program Services(5b)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

yes

A-E

In Network (INN)**Services****Optional/Mandatory
/ Both**

Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		




In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount



\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Yes
A/E

Services	In-Network
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services	In-Network
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

Yes

AEI

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services**In-Network**

Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral**Prior Authorization**

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AE

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$45.00	Every 3 months		Completed

yes

AEI

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed
Chronic Conditions - Please choose one or more			

Yes

AE

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description		
	Chronic Hypertension		
	Other 2 Description		
	Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description		
	Osteoporosis		
	Other 4 Description		
	Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package?		
	No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount?		
	No		
	Select the Medicare benefits that apply to reduced cost sharing		
	Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		

was

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Are any benefits exempt from the plan-level deductible?

No

Is there a maximum aggregated amount of reduced cost sharing?

Yes

Specify the maximum aggregated amount of reduced cost sharing:

\$100.00

Indicate mode of delivery for maximum coverage amount

Debit Card

Expected number of chronically ill enrollees eligible for SSBCI:

13743

Expected number of chronically ill enrollees that will utilize SSBCI:

13164

Notes

ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Medical Supplies (11b2) - Medicare

Min: 0% Max: 0%

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

AEI *was*

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$100.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

13743

Expected number of chronically ill enrollees that will utilize SSBCI:

13164

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

Package ID	Package Name	Type of Package	Status
Yes			
The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.			
true			
Are you offering Naloxone coverage as a Part C OTC benefit?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Does this cover all of the drugs on the CMS OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?			
No			
Mode of delivery for the OTC Items			
Debit Card			
Catalogue Purchase			
Authorization required for this benefit?			
No.			
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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.			

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Handwritten signatures: A.E. and cas

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

yes
A/E

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes

AE

Package ID	Package Name	Type of Package	Status
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.			
Adjunctive General Services (16c10) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.			
Eyewear (17b) - Non-Medicare			
Is there a maximum plan benefit coverage?			
No			
Is there a deductible?			
No			
Contact Lenses (17b1) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			

yes
AE

Package ID	Package Name	Type of Package	Status
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.			
Eyeglasses (lenses and frames) (17b2) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.			
Upgrades (17b5) - Non-Medicare			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			

Yes

AE

Package ID	Package Name	Type of Package	Status
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.			

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.			

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?	
No	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	
No	
Is there a coinsurance?	
No	
Is there a copayment?	
No	
Is there a deductible?	
No	
Mode of delivery for Food and Produce	
Debit Card	
Authorization required for this benefit?	
No	
Referral required for this benefit?	
No	
Notes	
ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.	

Yes

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

AE

Package ID	Package Name	Type of Package	Status
Yes			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			
Pest Control (13i3) - Non-Medicare			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			

AEI Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

AEI

Package ID	Package Name	Type of Package	Status
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AEI

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

Yes

AEI

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AE

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Yes

AE

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

AEI

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

Yes
A-E

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

AE

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

AEI

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Yes

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

AE

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Yes

AEI

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Yes

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes

AEI

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Yes

AE

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
A-E

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Yes

AE

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Yes

AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%

Yes
A-E

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE FOR DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Yes

AEI

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes
A-E

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

Yes

Att

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
AEI

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes
A/E

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AEI

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Yes

AE

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Yes

AEI

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes
A-E

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Yes

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Yes

AE

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Yes

AEI

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes
A/E

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Yes

AEI

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AE

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Yes

A.S.I.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

AEI

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Yes

AE

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes
All

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Yes
A/E

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Yes

A-E

ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes
AE

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AE Yes

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

Yes
AEI

Medicare-defined Part D Deductible amount	Medicare-defined Part D Coinsurance amount	Medicare-defined Part D Annual Out-of-Pocket cost threshold
\$700.00	25%	\$2400.00

Cap for one-month supply of
each Part D-covered insulin
\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

Yes

AEI

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment
\$105.00

Coinsurance 3-month supply
25%

Long-Term Care

Enter 1-month copayment
\$35.00

Long-Term Care Coinsurance
25%

Out-of-Network

Out-of-network 1-month
copayment
\$35.00

Out-of-Network Coinsurance
25%

AE Cas

was
A/E

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

H4004

ADMINISTRACIÓN DE SEGUROS DE SALUD

076 - 1 MMM HEALTHCARE, LLC - Data Report**27 - 0 0 0 0 2****Plan Characteristics****General Information**

NÚMERO DE CONTRATO

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Preciso Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP: None of the above (i.e., no buy-down applied)
No	No	

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

Yes

AEI

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	




Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

Yes

AE

In Network (INN)

Services	Optional/Mandatory / Both	
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory



Services	In Network (INN)	
		Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

yes

AE

In Network (INN)

Services	Optional/Mandatory / Both	
Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount



\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Yes

AE

Services**In-Network**

Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services**In-Network**

Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

yes
A-E

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services	In-Network
Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

AEI Yes

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$45.00	Every 3 months		Completed

Yes

AE

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically Ill?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed

Chronic Conditions - Please choose one or more

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description Chronic Hypertension		
	Other 2 Description Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description Osteoporosis		
	Other 4 Description Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package? No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount? No		
	Select the Medicare benefits that apply to reduced cost sharing Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		



Package ID	Package Name	Type of Package	Status
Are any benefits exempt from the plan-level deductible?			
No			
Is there a maximum aggregated amount of reduced cost sharing?			
Yes			
Specify the maximum aggregated amount of reduced cost sharing:			
\$185.00			
Indicate mode of delivery for maximum coverage amount			
Debit Card			
Expected number of chronically ill enrollees eligible for SSBCI:			
2148			
Expected number of chronically ill enrollees that will utilize SSBCI:			
1898			
Notes			
ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.			
Reduced Coinsurance			
Reduced Coinsurance?			
Yes			
Select the benefits that will receive reduced coinsurance			
Durable Medical Equipment (DME) (11a) - Medicare			
Min: 0% Max: 0%,			
Prosthetic Devices (11b1) - Medicare			
Min: 0% Max: 0%,			
Medical Supplies (11b2) - Medicare			
Min: 0% Max: 0%			
Reduced Copayment			
Reduced Copayment?			
No			
Reduced Deductible			
Reduced Deductible?			

Yes

AE

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

AEI *Yes*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$185.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

2148

Expected number of chronically ill enrollees that will utilize SSBCI:

1898

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Oral and Maxillofacial Surgery (16c8) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI was

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

AE *yes*

Package ID	Package Name	Type of Package	Status
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.			

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Handwritten signature and initials in blue ink, possibly reading "A. E. 4/25".

Package ID	Package Name	Type of Package	Status
	ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.		

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Package ID	Package Name	Type of Package	Status
Yes			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?	
No	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	
No	
Is there a coinsurance?	
No	
Is there a copayment?	
No	
Is there a deductible?	
No	
Authorization required for this benefit?	
No	
Referral required for this benefit?	

yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

AE Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

Yes
AE

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AEI *Yes*

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

Yes

AEI

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AEI Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes

AE

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Yes

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AL cas

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

AEI Yes

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI

was

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Yes

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Yes
AE

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%

AEI Yes

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE FOR DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

AEI Yes

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

yes

AE

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI Yes

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes
AEI

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

yes
A-E

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

yes

AEI

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI Yes

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

AEI *yes*

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Yes
A/E

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Yes
ALL

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

AEI Yes

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

AE/Yes

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Yes
AE

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI *yes*

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Handwritten signature and "yes" in blue ink.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

AEI Yes

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes



ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI *yes*

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

yes

AEI

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

Handwritten signature: A. E. Cas

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply



90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-NetworkOut-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%



was
A/E

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

H4004

ADMINISTRACIÓN DE SEGUROS DE SALUD

076 - 2 MMM HEALTHCARE, LLC - Data Report**27 - 0 0 0 0 2****Plan Characteristics****General Information**

NÚMERO DE CONTRATO

Organization Legal Name	Organization Marketing Name	Organization Type
MMM HEALTHCARE, LLC	Medicare y Mucho Mas (MMM)	Local CCP
Plan Name	Plan Geographic Name	
MMM Preciso Platino (HMO D-SNP)	Puerto Rico	

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Applicable	No
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No
Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?		
Not Available		

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Applicable
Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?	This DSNP: None of the above (i.e., no buy-down applied)
No	No	

Plan Attributes


Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?

No

Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan offer a standard bid for Visitor Travel Program V/T?

No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

Yes

AEI

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

In Network (INN)**Services****Optional/Mandatory
/ Both**

Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

In Network (INN)**Services****Optional/Mandatory
/ Both**

Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		




In Network (INN)**Services****Optional/Mandatory
/ Both**

Prescription Hearing Aids - Outer Ear(18b3)

Prescription Hearing Aids - Over the Ear(18b4)

OTC Hearing Aids(18c)

Plan Level Cost Sharing**Plan Level Cost Sharing****Tiered Cost Sharing**

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount



\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Yes

AEI

Services**In-Network**

Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services	In-Network
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

Yes

AE

Services**In-Network**

Hearing Exams(18a)

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services	In-Network
Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AE

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$45.00	Every 3 months		Completed

Yes
AEI

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically Ill?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed

Chronic Conditions - Please choose one or more

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description Chronic Hypertension		
	Other 2 Description Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description Osteoporosis		
	Other 4 Description Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package? No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount? No		
	Select the Medicare benefits that apply to reduced cost sharing Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Are any benefits exempt from the plan-level deductible?

No

Is there a maximum aggregated amount of reduced cost sharing?

Yes

Specify the maximum aggregated amount of reduced cost sharing:

\$155.00

Indicate mode of delivery for maximum coverage amount

Debit Card

Expected number of chronically ill enrollees eligible for SSBCI:

4085

Expected number of chronically ill enrollees that will utilize SSBCI:

3610

Notes

ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Medical Supplies (11b2) - Medicare

Min: 0% Max: 0%

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

AE *was*

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

AEI *was*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),
 Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$155.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
 Food and Produce (13i1),

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

4085

Expected number of chronically ill enrollees that will utilize SSBCI:

3610

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

Package ID**Package Name****Type of Package****Status**

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

AEI *was*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.			
Prosthodontics, fixed (16c7) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.			
Oral and Maxillofacial Surgery (16c8) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			

yes

AEI

Package ID	Package Name	Type of Package	Status
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.			
Adjunctive General Services (16c10) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.			
Eyewear (17b) - Non-Medicare			
Is there a maximum plan benefit coverage?			
No			
Is there a deductible?			
No			
Contact Lenses (17b1) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			



Package ID	Package Name	Type of Package	Status
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.			
Eyeglasses (lenses and frames) (17b2) - Non-Medicare			
	Is this benefit unlimited?		
	Yes		
	Is there a coinsurance?		
	No		
	Is there a copayment?		
	No		
	Authorization required for this benefit?		
	No		
	Referral required for this benefit?		
	No		
	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.			
Upgrades (17b5) - Non-Medicare			
	Is there a coinsurance?		
	No		
	Is there a copayment?		
	No		
	Authorization required for this benefit?		
	No		
	Referral required for this benefit?		
	No		
	Notes		



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

AEI yes

Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Package ID	Package Name	Type of Package	Status
Yes			
Is there a maximum plan benefit coverage amount?			
No			
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?			
No			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Is there a deductible?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.			

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?	
No	
Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?	
No	
Is there a coinsurance?	
No	
Is there a copayment?	
No	
Is there a deductible?	
No	
Authorization required for this benefit?	
No	
Referral required for this benefit?	



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

Yes

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

AEI was

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AEI *yes*

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

AEI *was*

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AEI Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

AEI was

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Yes
AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED
IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AL was

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

AEI Yes

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No



Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Yes

AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%

AEI *Yes*

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE FOR DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

Yes
All

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

yes
AE

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes



Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

ALL was

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

AEI *was*

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI *yes*

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

24

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Handwritten signature: A. E. Vas

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No



Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No



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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?



Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

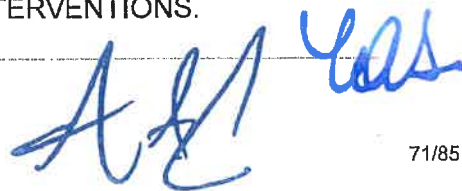
Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare



Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI was

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Handwritten signatures and initials in blue ink, including "AEL" and "yes".

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

AEI *yes*

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Handwritten signature: A. E. [unclear] and "Yes" in blue ink.

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$2000.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

ALL yes

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

yes

AL

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes



ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Handwritten signatures: "A-E" and "yes"

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

AEI was

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

AEI

was

Medicare-defined Part D
Deductible amount

\$700.00

Medicare-defined Part D
Coinsurance amount

25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold

\$2400.00

Cap for one-month supply of
each Part D-covered insulin

\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-Network

Out-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%

AEI cas

was
A/E

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2027

Requested By: CHRISTIAN SOTOMAYOR

H4004**076 - 3 MMM HEALTHCARE, LLC - Data Report**

ADMINISTRACIÓN DE SEGUROS DE SALUD

27 - 0 0 0 0 2**Plan Characteristics****General Information**

NÚMERO DE CONTRATO

Organization Legal Name

Organization Marketing Name

Organization Type

MMM HEALTHCARE, LLC

Medicare y Mucho Mas (MMM)

Local CCP

Plan Name

Plan Geographic Name

MMM Preciso Platino (HMO D-SNP)

Puerto Rico

Plan Details

Plan Type

Is this a network plan?

Is this an Employer-Only Plan?

HMO

Not Applicable

No

Does this plan offer Prescription drugs (Rx)?

Does this plan offer Point of Service (POS)?

Does this plan offer Out-of-Network Services (OON)?

Yes

No

No

Does this plan participate in the Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model?

Not Available

Special Needs Plan

Is this a SNP?

SNP Type

SNP Institutional Type

Yes

Dual-Eligible

Not Applicable

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?

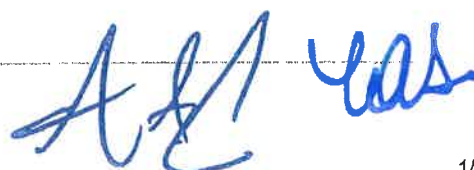
Under this D-SNP, has the state agreed to cover all Medicare Part C premiums and Part C cost sharing for enrollees in your D-SNP?

This DSNP:

No

No

None of the above (i.e., no buy-down applied)

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Contract Year 2027 Medicare-defined MOOP Limits (HMO Plan)

Lower MOOP Limit	Intermediate MOOP Limit	Mandatory MOOP Limit
\$0 - \$4450 In-network	\$4451 - \$7150 In-network	\$7151 - \$9850 In-network

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required

yes

AEI

Services**In Network (INN)****Partial Hospitalization/Intensive Outpatient Program Services(5)**

Partial Hospitalization Program(5a)

Required

Intensive Outpatient Program Services(5b)

Required

Home Health Services(6)

Required

Health Care Professional Services(7)

Primary Care Physician Services(7a)

Required

Chiropractic Services(7b)

Required

Occupational Therapy Services(7c)

Required

Physician Specialist Services(7d)

Required

Mental Health Specialty Services(7e)

Individual Sessions for Mental Health Specialty Services(7e1)

Required

Group Sessions for Mental Health Specialty Services(7e2)

Required

Podiatry Services(7f)

Required

Other Health Care Professional(7g)

Required

Psychiatric Services(7h)

Individual Sessions for Psychiatric Services(7h1)

Required

Group Sessions for Psychiatric Services(7h2)

Required

Physical Therapy and Speech-Language Pathology Services(7i)

Required

Additional Telehealth Benefits(7j)

Yes

Opioid Treatment Program Services(7k)

Required

Outpatient Procedures, Tests, Labs and Radiology Services(8)

Diagnostic Procedures/Tests/Lab Services(8a)

Diagnostic Procedures/Tests(8a1)

Required

Lab Services(8a2)

Required

Outpatient Diagnostic/Therapeutic Radiological Services(8b)

Diagnostic Radiological Services(8b1)

Required

Therapeutic Radiological Services(8b2)

Required

Outpatient X-Ray Services(8b3)

Required

Outpatient Services(9)

Outpatient Hospital Services(9a)

Services	In Network (INN)
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Diabetic Monitors(11c3)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	

Services	In Network (INN)
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Medicare Dental Services(16a)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)		
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		

Handwritten signatures: AEL and yas

In Network (INN)**Services****Optional/Mandatory
/ Both**

Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)	Required	Mandatory
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)	Required	Mandatory
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory

was

AEL

Services	In Network (INN)	
		Optional/Mandatory / Both
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)	Required	Mandatory
Fitness Benefit(14c4)	Required	Mandatory
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)	Required	Mandatory
Counseling Services(14c9)		
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)		
Dental(16)		
Diagnostic and Preventive Dental(16b)		
Oral Exams(16b1)		
Dental X-Rays(16b2)		
Other Diagnostic Dental Services(16b3)		

In Network (INN)

Services		Optional/Mandatory / Both
Prophylaxis (cleaning)(16b4)		
Fluoride Treatment(16b5)		
Other Preventive Dental Services(16b6)		
Comprehensive Dental(16c)		
Restorative Services(16c1)	Required	Mandatory
Endodontics(16c2)		
Periodontics(16c3)		
Prosthodontics, removable(16c4)	Required	Mandatory
Maxillofacial Prosthetics(16c5)		
Implant Services(16c6)	Required	Mandatory
Prosthodontics, fixed(16c7)	Required	Mandatory
Oral and Maxillofacial Surgery(16c8)		
Orthodontics(16c9)		
Adjunctive General Services(16c10)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)		
Other Eye Exam Services(17a2)		
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)		
Eyeglass frames(17b4)		
Upgrades(17b5)		
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)		
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Prescription Hearing Aids(18b)		
Prescription Hearing Aids (all types)(18b1)	Required	Mandatory
Prescription Hearing Aids - Inner Ear(18b2)		




Services	In Network (INN) Optional/Mandatory / Both
Prescription Hearing Aids - Outer Ear(18b3)	
Prescription Hearing Aids - Over the Ear(18b4)	
OTC Hearing Aids(18c)	

Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

AEI *Yes*

\$3250.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

In-Network Non-Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization/Intensive Outpatient Program Services(5)	
Partial Hospitalization Program(5a)	Yes
Intensive Outpatient Program Services(5b)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes

Handwritten signature: A. E. [unclear] with "yes" written next to it.

Services**In-Network**

Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	

Services	In-Network
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Diabetic Monitors(11c3)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Medicare Dental Services(16a)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	

Services

Hearing Exams(18a)

In-Network

Yes

Non-Medicare Services

Select the Non-Medicare service categories that are subject to each MOOP type:

Services**In-Network**

Emergency/Urgently Needed Services(4)

Worldwide Emergency/Urgent Coverage(4c)

Worldwide Emergency Coverage(4c1)

Yes

Worldwide Urgent Coverage(4c2)

Yes

Health Care Professional Services(7)

Chiropractic Services(7b)

Routine Chiropractic Care(7b1)

Yes

Podiatry Services: Routine Foot Care(7f)

Yes

Ambulance/Transportation Services(10)

Transportation Services(10b)

Transportation Services - Plan Approved Health-related Location(10b1)

Yes

Other Supplemental Services(13)

Acupuncture Treatments(13a)

Yes

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

Yes

Meal Benefit(13c)

Yes

Preventive and Other Defined Supplemental Services(14)

Other Defined Supplemental Benefits(14c)

Health Education(14c1)

Yes

Nutritional/Dietary Benefit(14c2)

Yes

Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)

Yes

Fitness Benefit(14c4)

Yes

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

Yes

Home and Bathroom Safety Devices and Modifications(14c8)

Yes

Alternative Therapies(14c17)

Yes

Services	In-Network
Dental(16)	
Comprehensive Dental(16c)	
Restorative Services(16c1)	Yes
Prosthodontics, removable(16c4)	Yes
Implant Services(16c6)	Yes
Prosthodontics, fixed(16c7)	Yes
Adjunctive General Services(16c10)	Yes
Eye Exams/Eyewear(17)	
Eyewear(17b)	
Contact Lenses(17b1)	Yes
Eyeglasses (lenses and frames)(17b2)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	
Fitting/Evaluation for Hearing Aid(18a2)	Yes
Prescription Hearing Aids(18b)	
Prescription Hearing Aids (all types)(18b1)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Inpatient Hospital-Acute(1a)
 Inpatient Hospital Psychiatric(1b)
 Skilled Nursing Facility (SNF)(2)
 Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Home Health Services(6)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)

Yes

AE

Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Individual Sessions for Psychiatric Services(7h1)
Group Sessions for Psychiatric Services(7h2)
Physical Therapy and Speech-Language Pathology Services(7i)
Additional Telehealth Benefits(7j)
Opioid Treatment Program Services(7k)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Individual Sessions for Outpatient Substance Abuse(9c1)
Group Sessions for Outpatient Substance Abuse(9c2)
Outpatient Blood Services(9d)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Transportation Services - Plan Approved Health-related Location(10b1)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Diabetic Supplies(11c1)
Diabetic Therapeutic Shoes/Inserts(11c2)
Diabetic Monitors(11c3)
Dialysis Services(12)
Acupuncture Treatments(13a)
Meal Benefit(13c)
Medicare-covered Zero Dollar Preventive Services(14a)
Health Education(14c1)
Nutritional/Dietary Benefit(14c2)
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)
Fitness Benefit(14c4)
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)
(14c7)
Home and Bathroom Safety Devices and Modifications(14c8)
Alternative Therapies(14c17)
Kidney Disease Education Services(14d)
Glaucoma Screening(14e1)
Diabetes Self-Management Training(14e2)
Digital Rectal Exams(14e4)
EKG following Welcome Visit(14e5)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Medicare Dental Services(16a)
Restorative Services(16c1)
Prosthodontics, removable(16c4)
Implant Services(16c6)
Prosthodontics, fixed(16c7)
Adjunctive General Services(16c10)
Eye Exams(17a)
Eyewear(17b)
Contact Lenses(17b1)
Eyeglasses (lenses and frames)(17b2)



Hearing Exams(18a)
 Fitting/Evaluation for Hearing Aid(18a2)
 Prescription Hearing Aids (all types)(18b1)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Cardiac Rehabilitation Services(3-1)
 Intensive Cardiac Rehabilitation Services(3-2)
 Pulmonary Rehabilitation Services(3-3)
 SET for PAD Services(3-4)
 Partial Hospitalization Program(5a)
 Intensive Outpatient Program Services(5b)
 Chiropractic Services(7b)
 Routine Chiropractic Care(7b1)
 Occupational Therapy Services(7c)
 Physician Specialist Services(7d)
 Individual Sessions for Mental Health Specialty Services(7e1)
 Group Sessions for Mental Health Specialty Services(7e2)
 Podiatry Services(7f)
 Podiatry Services: Routine Foot Care(7f)
 Other Health Care Professional(7g)
 Individual Sessions for Psychiatric Services(7h1)
 Group Sessions for Psychiatric Services(7h2)
 Individual Sessions for Outpatient Substance Abuse(9c1)
 Group Sessions for Outpatient Substance Abuse(9c2)
 Acupuncture Treatments(13a)
 Meal Benefit(13c)

Visitor Travel

Does this plan offer the US
 Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
OTC COMBINED PACKAGE	Catalogue Purchase	\$45.00	Every 3 months		Completed

Yes

AEI

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
------------	------------------	--------------------------------------	-------------	---------------------------	--------

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

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

Fitness Benefit(14c4)

Home and Bathroom Safety Devices and Modifications(14c8)

Is the enrollee limited to one or more of the Combined Supplemental Benefits from the group which they must select in advance?

No

Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?

Yes

Do you offer Combined Supplemental Benefits with a shared visit/trips limits?

No

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

MA Uniformity & SSBCI

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for the Chronically.III?

Yes

MA UF/SSBCI Reduction in Cost Sharing Packages (19a)

Package ID	Package Name	Type of Package	Status
1	DEBIT CARD	SSBCI	Completed

Chronic Conditions - Please choose one or more

Package ID	Package Name	Type of Package	Status
	Chronic alcohol use disorder and other substance use disorders (SUDs), Autoimmune disorders, Cancer, Cardiovascular disorders, Chronic heart failure, Dementia, Diabetes mellitus, Overweight, obesity, and metabolic syndrome, Chronic gastrointestinal disease, Chronic kidney disease (CKD), Severe hematologic disorders, HIV/AIDS, Chronic lung disorders, Chronic and disabling mental health conditions, Neurologic disorders, Stroke, Post-organ transplantation, Immunodeficiency and Immunosuppressive disorders, Conditions associated with cognitive impairment, Conditions with functional challenges, Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell, Conditions that require continued therapy services in order for individuals to maintain or retain functioning, Other 1, Other 2, Other 3, Other 4		
	Other 1 Description		
	Chronic Hypertension		
	Other 2 Description		
	Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%		
	Other 3 Description		
	Osteoporosis		
	Other 4 Description		
	Chronic Back Pain		
	Prerequisite for reduction of cost sharing for this package?		
	No		
	Does the plan reduce cost sharing to \$0 for all covered benefits, up to a maximum aggregate amount?		
	No		
	Select the Medicare benefits that apply to reduced cost sharing		
	Durable Medical Equipment (DME) (11a), Prosthetic Devices (11b1), Medical Supplies (11b2)		

yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Are any benefits exempt from the plan-level deductible?

No

Is there a maximum aggregated amount of reduced cost sharing?

Yes

Specify the maximum aggregated amount of reduced cost sharing:

\$175.00

Indicate mode of delivery for maximum coverage amount

Debit Card

Expected number of chronically ill enrollees eligible for SSBCI:

10789

Expected number of chronically ill enrollees that will utilize SSBCI:

9535

Notes

ELIGIBLE MEMBERS RECEIVE ALLOWANCE ADMINISTERED THROUGH A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

Reduced Coinsurance

Reduced Coinsurance?

Yes

Select the benefits that will receive reduced coinsurance

Durable Medical Equipment (DME) (11a) - Medicare

Min: 0% Max: 0%,

Prosthetic Devices (11b1) - Medicare

Min: 0% Max: 0%,

Medical Supplies (11b2) - Medicare

Min: 0% Max: 0%

Reduced Copayment

Reduced Copayment?

No

Reduced Deductible

Reduced Deductible?

AEI *yes*

Package ID	Package Name	Type of Package	Status
No			

MA UF/SSBCI Additional Benefits Packages (19b)

Package ID	Package Name	Type of Package	Status
1	SSBCI Coverage	SSBCI	Completed

Chronic Conditions - Please choose one or more

Chronic alcohol use disorder and other substance use disorders (SUDs),
 Autoimmune disorders,
 Cancer,
 Cardiovascular disorders,
 Chronic heart failure,
 Dementia,
 Diabetes mellitus,
 Overweight, obesity, and metabolic syndrome,
 Chronic gastrointestinal disease,
 Chronic kidney disease (CKD),
 Severe hematologic disorders,
 HIV/AIDS,
 Chronic lung disorders,
 Chronic and disabling mental health conditions,
 Neurologic disorders,
 Stroke,
 Post-organ transplantation,
 Immunodeficiency and Immunosuppressive disorders,
 Conditions associated with cognitive impairment,
 Conditions with functional challenges,
 Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell,
 Conditions that require continued therapy services in order for individuals to maintain or retain functioning,
 Other 1,
 Other 2,
 Other 3,
 Other 4

Other 1 Description

Chronic Hypertension

Other 2 Description

Pre-diabetes: Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%

Other 3 Description

Osteoporosis

Other 4 Description

Chronic Back Pain

Prerequisite for any additional benefits for this package?

was

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
Meals (beyond limited basis) (13i2),
Pest Control (13i3),
Social Needs Benefit (13i6),
General Supports for Living (13i10),
Other 1 (13i11),
Other 3 (13i13),
Fitness Benefit (14c4),
Home and Bathroom Safety Devices and Modifications (14c8),
Oral Exams (16b1),
Dental X-Rays (16b2),
Other Diagnostic Dental Services (16b3),
Restorative Services (16c1),
Endodontics (16c2),
Periodontics (16c3),
Prosthodontics, removable (16c4),
Implant Services (16c6),
Prosthodontics, fixed (16c7),
Oral and Maxillofacial Surgery (16c8),
Adjunctive General Services (16c10),
Contact Lenses (17b1),
Eyeglasses (lenses and frames) (17b2),
Upgrades (17b5),
Fitting/Evaluation for Hearing Aid (18a2),
Prescription Hearing Aids (all types) (18b1),
Transportation for Non-Medical Needs (13i4),
Indoor Air Quality Equipment Services (13i5)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

\$175.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

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

Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Meals (beyond limited basis) (13i2),
 Pest Control (13i3),
 Transportation for Non-Medical Needs (13i4),
 Indoor Air Quality Equipment Services (13i5),
 Social Needs Benefit (13i6),
 General Supports for Living (13i10),
 Other 1 (13i11),
 Other 3 (13i13),
 Fitness Benefit (14c4),
 Home and Bathroom Safety Devices and Modifications (14c8),
 Oral Exams (16b1),
 Dental X-Rays (16b2),
 Other Diagnostic Dental Services (16b3),
 Restorative Services (16c1),
 Endodontics (16c2),
 Periodontics (16c3),
 Prosthodontics, removable (16c4),
 Implant Services (16c6),
 Prosthodontics, fixed (16c7),
 Oral and Maxillofacial Surgery (16c8),
 Adjunctive General Services (16c10),
 Contact Lenses (17b1),
 Eyeglasses (lenses and frames) (17b2),
 Upgrades (17b5),
 Fitting/Evaluation for Hearing Aid (18a2),
 Prescription Hearing Aids (all types) (18b1)

Expected number of chronically ill enrollees eligible for SSBCI:

10789

Expected number of chronically ill enrollees that will utilize SSBCI:

9535

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO SSBCI PACKAGE BENEFITS THROUGH A DEBIT CARD LOADED WITH THE COMBINED PACKAGE-LEVEL MAXIMUM COVERAGE AMOUNT PLUS AN ADDITIONAL BENEFIT-SPECIFIC MAXIMUM COVERAGE AMOUNT FOR SPECIFIC BENEFITS REFERENCED IN 13I-3, 13I-4, 13I-5, AND 13I-10.

Package Selected Benefit Details

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Mode of delivery for the OTC Items

Debit Card

Catalogue Purchase

Authorization required for this benefit?

No

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

Yes
AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Fitness Benefit (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Physical Fitness

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR FITNESS EQUIPMENT (EXERCISE PEDALS AND STRETCH STRAPS) AND A GYM MEMBERSHIP VIA A DEBIT CARD. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

AEI *was*

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE AN ALLOWANCE FOR THE FOLLOWING ITEMS VIA A DEBIT CARD: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Diagnostic and Preventive Dental (16b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a Coinsurance for combination of services included in a single cost per office visit?

No

Is there a Copayment for combination of services included in a single cost per office visit?

No

Is there a deductible?

No

Oral Exams (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL EXAMS VIA A DEBIT CARD.

yes

AEI

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Dental X-Rays (16b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL X-RAYS VIA A DEBIT CARD.

Other Diagnostic Dental Services (16b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL DIAGNOSTIC SERVICES VIA A DEBIT CARD.

Comprehensive Dental (16c) - Non-Medicare

Service maximum plan benefit coverage:

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a deductible?

No

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL RESTORATIVE DENTAL SERVICES VIA A DEBIT CARD.

Endodontics (16c2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ENDODONTIC SERVICES VIA A DEBIT CARD.

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Periodontics (16c3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL PERIODONTIC SERVICES VIA A DEBIT CARD.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL REMOVABLE PROSTHODONTIC SERVICES VIA A DEBIT CARD.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

Package ID	Package Name	Type of Package	Status
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL DENTAL IMPLANT SERVICES VIA A DEBIT CARD.			
Prosthodontics, fixed (16c7) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			
No			
Referral required for this benefit?			
No			
Notes			
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL FIXED PROSTHODONTIC SERVICES VIA A DEBIT CARD.			
Oral and Maxillofacial Surgery (16c8) - Non-Medicare			
Is this benefit unlimited?			
Yes			
Is there a coinsurance?			
No			
Is there a copayment?			
No			
Authorization required for this benefit?			



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ORAL AND MAXILLOFACIAL SERVICES VIA A DEBIT CARD.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL ADJUNCTIVE DENTAL SERVICES VIA A DEBIT CARD.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

AEI was

Package ID	Package Name	Type of Package	Status
No	Authorization required for this benefit?		
No	Referral required for this benefit?		
No	Notes		
ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL CONTACT LENSES VIA A DEBIT CARD.			

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR VIA A DEBIT CARD.

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes



Package ID	Package Name	Type of Package	Status
	ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL EYEWEAR UPGRADES VIA A DEBIT CARD.		

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AID FITTING/EVALUATIONS VIA A DEBIT CARD.

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

No

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?



Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS ADDITIONAL HEARING AIDS VIA A DEBIT CARD.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Mode of delivery for Food and Produce

Debit Card

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO FOOD AND PRODUCE THROUGH A DEBIT CARD.

Meals (beyond limited basis) (13i2) - Non-Medicare

Is this benefit unlimited?

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PREPARED MEALS THROUGH A DEBIT CARD.

Pest Control (13i3) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

AL

was

Package ID	Package Name	Type of Package	Status
No			

Notes

ELIGIBLE MEMBERS RECEIVE PEST CONTROL/ERADICATION TREATMENTS (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS, AND INDOOR AIR QUALITY EQUIPMENT SERVICES) LIMITED TO 2 EVENTS (1/SEMESTER). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO CLEANING PRODUCTS FOR PEST CONTROL AND FOR ADDITIONAL SERVICES OF PEST CONTROL/ERADICATION TREATMENTS.

Transportation for Non-Medical Needs (13i4) - Non-Medicare

Enhanced benefit

Any Location

Is this benefit unlimited?

Yes

Type of transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Select Mode of Transportation

Other, Describe

Description

AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

AE

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE ROADSIDE ASSISTANCE (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES.) ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL ROADSIDE ASSISTANCE SERVICES TO SUPPORT PERSONAL TRANSPORTATION AND AUTOMOBILE GASOLINE TO FACILITATE TRANSPORTATION NEEDS TO MAINTAIN THE ENROLLEE'S HEALTH.

Indoor Air Quality Equipment Services (13i5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS RECEIVE UP TO 2 A/C CLEANING SERVICES PER YEAR (1/SEMESTER) (12 EVENTS COMBINED WITH IN-HOME MINOR REPAIRS (UP TO \$300 PER EVENT), PEST CONTROL, AND ROADSIDE ASSISTANCE). ADDITIONALLY, MEMBERS RECEIVE AN ALLOWANCE THROUGH A DEBIT CARD WHICH PROVIDES ACCESS TO ADDITIONAL A/C CLEANING SERVICES TO SUPPORT HEALTHY INDOOR AIR QUALITY, REDUCE EXPOSURE TO ALLERGENS AND ENVIRONMENTAL IRRITANTS, AND PROMOTE SAFE TEMPERATURE REGULATION IN THE HOME.

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Package ID	Package Name	Type of Package	Status
No			
	Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?		
No			
	Is there a coinsurance?		
No			
	Is there a copayment?		
No			
	Is there a deductible?		
No			
	Authorization required for this benefit?		
No			
	Referral required for this benefit?		
No			

Notes

ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE TICKETS TO ATTEND ENTERTAINMENT EVENTS (CONCERT, THEATER, MOVIE) AND PERSONAL GROOMING SERVICES (BARBER OR SALON VISITS) THROUGH A DEBIT CARD. ENGAGING IN ENTERTAINMENT CAN BE BENEFICIAL FOR DEALING WITH SOCIAL ISOLATION AND IMPROVING MENTAL HEALTH AND WELLBEING. BY PROVIDING OPPORTUNITIES FOR RELAXATION, SOCIAL INTERACTION, AND ENJOYABLE EXPERIENCES, THESE ACTIVITIES CONTRIBUTE TO THE OVERALL PSYCHOLOGICAL RESILIENCE AND HAPPINESS OF ENROLLEES.

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Are you offering housing support such as rent or mortgage assistance as a covered benefit under General Supports for Living?

No

Are you offering utilities assistance as a covered benefit under General Supports for Living?

Yes

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

Yes

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TOWARDS UTILITIES, TOWELS/LINENS/CLOTHING (TO SUPPORT BASIC NEEDS), GARDENING/HARDWARE TOOLS (FOR HOME MAINTENANCE) AND IN-HOME MINOR REPAIRS, INCLUDING REPAIRS FOR HOME APPLIANCES AND HANDYMAN SERVICES (12 EVENTS COMBINED WITH ROADSIDE ASSISTANCE (\$300 LIMIT PER EACH EVENT, \$200 LIMIT FOR EACH REPAIR OF HOME APPLIANCES), PEST CONTROL, AND INDOOR AIR QUALITY EQUIPMENT SERVICES). LIMIT OF 2 EVENTS FOR PEST CONTROL, HOME APPLIANCE REPAIRS, AND A/C CLEANING SERVICES (1/SEMESTER) AND 1 EVENT (UP TO 2 HOURS) FOR HANDYMAN SERVICES. ALLOWANCE FOR ADDITIONAL IN-HOME MINOR REPAIRS VIA THE DEBIT CARD. POOR-QUALITY HOUSING IS ASSOCIATED WITH VARIOUS NEGATIVE HEALTH OUTCOMES, INCLUDING CHRONIC DISEASE AND INJURY AND POOR MENTAL HEALTH. LACK OF HOUSING MAINTENANCE MAY LEAD TO POOR HOUSING CONDITIONS INSIDE AND OUTSIDE THE HOME. PROVIDING THE TOOLS FOR THE MEMBER TO MAINTAIN THEIR HOMES IN GOOD CONDITIONS IMPROVES THEIR PHYSICAL, MENTAL, AND SOCIAL WELLBEING.

Other 1 (13i11) - Non-Medicare

Service Name

PET CARE

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Handwritten signatures:
 A-E (large signature)
 was (small signature)

Package ID	Package Name	Type of Package	Status
No			
	Referral required for this benefit?		
No			
	Notes		
	ELIGIBLE MEMBERS HAVE ACCESS TO PURCHASE PET FOOD, PET SUPPLIES (LEASH, COLLAR, GROOMING SUPPLIES), AND PET SERVICES (VET VISITS AND GROOMING SERVICES) THROUGH A DEBIT CARD TO SUPPORT ELIGIBLE ENROLLEES' MENTAL HEALTH NEEDS. PROVIDING ELIGIBLE MEMBERS WITH THE MEANS TO RESPONSIBLY CARE FOR THEIR PETS WILL HAVE A DIRECT IMPACT ON THEIR HEALTH. PET OWNERS ARE LESS LIKELY TO SUFFER DEPRESSION, HAVE LOWER BLOOD PRESSURE, DISPLAY REDUCED LEVELS OF TRIGLYCERIDE AND CHOLESTEROL (HIGH LEVELS CAN BE INDICATORS OF HEART DISEASE), SURVIVE LONGER AFTER HAVING A HEART ATTACK, MAKE FEWER VISITS TO THE DOCTOR, AND TEND TO LIVE LONGER. OFFERING ACCESS TO PET CARE SUPPLIES ALLOWS OUR BENEFICIARIES TO ACCESS THE ITEMS NEEDED FOR PET OWNERSHIP AND WILL THEREFORE RESULT IN IMPROVED OR MAINTAINED HEALTH.		

Other 3 (13i13) - Non-Medicare

Service Name

MEMORY AND COGNITIVE FUNCTION SUPPORT ITEMS

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

ELIGIBLE MEMBERS HAVE ALLOWANCE TO PURCHASE MEMORY FITNESS ITEMS SUCH AS: MEMORY CARDS, BOARD GAMES, SUDOKU OR OTHER ITEMS THAT HELP THE MEMBER EXERCISE THEIR MEMORY. STUDIES HAVE FOUND THAT

yes

AL

Package ID	Package Name	Type of Package	Status
------------	--------------	-----------------	--------

INDIVIDUALS WHO ENGAGED IN WORD PUZZLES HAD CONSISTENTLY BETTER SHORT-TERM MEMORY, REASONING, AND ATTENTIVENESS THAN THOSE WHO DID NOT ENGAGE IN SUCH ACTIVITIES. THIS SUPPORTS THE THEORY THAT KEEPING THE MIND ACTIVE, IN ADDITION TO REGULAR PHYSICAL EXERCISE, MAY HELP SLOW THE ONSET OF DEMENTIA.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

Yes

Days

0

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?



No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

yes

AEI

Yes

Referral required for this benefit?

Yes

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Urgently Needed Services (4b) - Medicare

AEI was

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Partial Hospitalization Program (5a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Intensive Outpatient Program Services (5b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

AEI

Referral required for this benefit?

Yes

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

AEI Yes

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

AE *yes*

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Yes

AEI

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Yes

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Yes

Physician Specialist Services(7d)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

ALL was

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

AEI was

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AE was

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

AEI *yes*

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Do you waive the deductible for the first three pints of blood?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

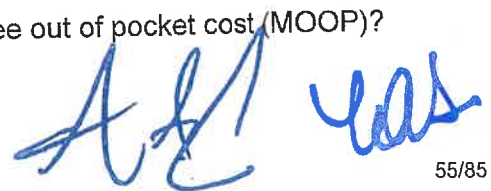
Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No



Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Referral required for this benefit?

No

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance

0%

Maximum coinsurance

10%

AEI *Yes*

Is there a copayment?

No

Is there a deductible?

No

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

MINIMUM COINSURANCE FOR DME SUPPLIES, WHEELCHAIR, DME POWER WHEELCHAIR AND ALL OTHER DME. MAXIMUM COINSURANCE FOR DME HOSP BED.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medical Supplies (11b2) - Medicare

AE was

Is there a coinsurance?

Yes

Coinsurance percentage

20%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

No

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

Handwritten signatures: "AEL" and "was"

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Diabetic Monitors (11c3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

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

Yes
AE

true

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI *was*

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Handwritten signature: A. E. [unclear] and "yes" in blue ink.

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes



Referral required for this benefit?

No

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Medicare Dental Services (16a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

AE *yes*

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

AEI

yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

AEI *Yes*

Is this Copayment waived if admitted to hospital?

Yes

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

Yes

Copayment amount

\$75.00

Is this Copayment waived if admitted to hospital?

Yes

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

\$750.00

Periodicity

Every Year

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

ALL yes

Yes

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

6

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Transportation Services - Plan Approved Health-related Location (10b1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

18

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

AEI *was*

Taxi
RideShare services
Bus/Subway
Van

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNLIMITED TRIPS APPLY TO AND FROM THE MULTI SPECIALTY CLINICS. LIMITED TRIPS PER THE DATA ENTRY APPLY TO ALL OTHER PLAN APPROVED HEALTH RELATED LOCATIONS.

Acupuncture Treatments (13a) - Non-Medicare

Periodicity

Every Year

Is there a maximum plan benefit coverage?

Yes

Maximum amount

\$500.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

6

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Are you offering Naloxone coverage as a Part C OTC benefit?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

AEI *yes*

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

No

Mode of delivery for the OTC Items

Catalogue Purchase

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 BLOOD PRESSURE MONITOR (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 SUCH AS ARM SLING, TENNIS ELBOW STRAP, WRIST SPLINT, WRIST WRAP, BACK SUPPORT BELT, ANKLE SUPPORT, KNEE ELASTIC W/STAYS, ETC. 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) COVID-19 TESTS 13) HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Meal Benefit (13c) - Non-Medicare

Select the type of primarily health related meals benefit offered(Check all that apply):

Immediately following surgery or inpatient hospitalization

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

AEI *yes*

Yes

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

6

Setting

Both Sessions (Individual and Group)

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Sessions of Smoking and Tobacco Cessation Counseling (14c3) - Non-Medicare

Number of visits

9

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

AEI *was*

Yes

Referral required for this benefit?

No

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 (14c4) - Non-Medicare

Indicate the type(s) of fitness benefits offered(check all that apply):

Fitness Equipment or Kit

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

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 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.

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Home and Bathroom Safety Devices and Modifications (14c8) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS.

Comprehensive Dental (16c) - Non-Medicare

Yes

AEI

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$1500.00

Periodicity

Every Year

Is the maximum plan benefit coverage amount entered exclusively part of a Combined Supplemental Benefits (CSB) group?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Restorative Services (16c1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Yes

Referral required for this benefit?

No

Notes

CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE IN ADDITION TO CROWN COVERED ONE PER TOOTH PER LIFE. SINGLE CROWNS COVERED UP TO ONE PER YEAR. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH, BY REPORT IF REPLACEMENT IS NEEDED. SINGLE CROWNS REQUIRE PRE AUTHORIZATION. PROVISIONAL CROWNS ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS. LABIAL VENEER ARE COVERED ONE (1) PER TOOTH EVERY FIVE (5) YEARS.

Prosthodontics, removable (16c4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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 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.

Handwritten signature and initials in blue ink, appearing to be 'A.E.' and 'was'.

Implant Services (16c6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

UP TO 1 IMPLANT A YEAR. 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 PERFORMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED.

Prosthodontics, fixed (16c7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description



PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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.

Adjunctive General Services (16c10) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

PERIODICITY VARIES BY SERVICE

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes



ANESTHESIA UNDER DEEP SEDATION IS COVERED. THE FIRST 15 MINUTES AND 3 ADDITIONAL 15 MINUTE INCREMENTS ARE COVERED FOR A TOTAL OF 60 MINUTES COMBINED PER DAY OF SERVICE. DEEP SEDATION SERVICES ARE APPLICABLE FOR PAYMENT WHEN THE FOLLOWING SERVICES ARE PERFORMED: SURGICAL PLACEMENT OF THE IMPLANT BODY, ENDOSSEOUS IMPLANT, SURGICAL EXTRACTION OF PROTRUDING TOOTH OR RESIDUAL ROOT, REMOVAL OF IMPACTED TEETH – IN SOFT TISSUE, REMOVAL OF PARTIALLY OR COMPLETELY IMPACTED TEETH IN BONE, REMOVAL OF RESIDUAL TOOTH ROOTS, REMOVAL OF THE PALATINE TORUS, MANDIBULAR TORUS AND REMOVAL OF EXOSTOSIS. AUTHORIZATION RULES APPLY TO DEEP SEDATION SERVICES. SERVICES AND MATERIALS NOT LISTED ABOVE ARE NOT COVERED BY THE PLAN.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

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

Combined maximum amount

\$600.00

Periodicity

Every Year

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

AEI *was*

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

yes
A/E

Referral required for this benefit?

No

Prescription Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

\$600.00

Periodicity

Every 3 Years

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Prescription Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Rx

Rx Characteristics

yes
A-E

Medicare-defined Part D
Deductible amount
\$700.00

Medicare-defined Part D
Coinsurance amount
25%

Medicare-defined Part D
Annual Out-of-Pocket cost
threshold
\$2400.00

Cap for one-month supply of
each Part D-covered insulin
\$35

Rx Setup

Select the type of drug benefit

Defined Standard

Retail

Standard Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 5, 2026, at 11:59 am Eastern Time.

No

Defined Standard - Locations and Location Supply

Standard Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

AEI was

90

Long-Term Care

Select days for long-term care supply

31

Out-of-Network

Select days for out of network 1-month supply

30

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

No

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

No

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

DS Insulin Cost Share

The enrollee cost sharing for each prescription fill up to a one-month supply for a covered insulin product, consistent with § 423.100 and 423.120(h), will not exceed the lesser of (1) \$35; (2) an amount equal to 25 percent of the maximum fair price established for the covered insulin product in accordance with part E of subchapter XI, or (3) an amount equal to 25 percent of the negotiated price, as defined in § 423.100, of the covered insulin product under the prescription drug plan or MA-PD plan. If submitted insulin cost sharing is less than either \$35 or 25%, I attest that enrollee cost sharing will not exceed the lesser of those cost sharing values.

Yes

Standard Retail

Enter 1-month copayment

\$35.00

Coinsurance 1-month supply

25%

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Standard Mail-Order

Enter 3-month copayment

\$105.00

Coinsurance 3-month supply

25%

Long-Term Care

Enter 1-month copayment

\$35.00

Long-Term Care Coinsurance

25%

Out-of-NetworkOut-of-network 1-month
copayment

\$35.00

Out-of-Network Coinsurance

25%



was

AE