MEDICARE PLATINO CONTRACT

APPENDIX C (1) (23)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 017, SEGMENT 0

Module:	PBP
Requested By:	rcqg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/01/2022 10:16:47 AM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 01:53:12 PM SA Western Standard Time
PD BPT Timestamp:	06/03/2022 02:46:42 PM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

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

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	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of	No

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discharge?	
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #2 SNF - BASE 6	
Is there an enrollee Copayment?	No
SECTION B: #2 SNF - BASE 10	

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What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

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

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

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

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

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

Is there an enrollee Copayment?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	Yes

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Coverage?	
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	500.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

Is there an enrollee Copayment?	No

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

Is authorization required?	Yes

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7d: Physician Specialist Services
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

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

Is there a service-specific Maximum Enrollee	No

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes

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

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

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Is there an enrollee Coinsurance?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3	
Is authorization required?	Yes
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: #13A ACUPUNCTURE - BASE 2

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

SECTION B: #13B OTC ITEMS – BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	100.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

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SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING

	SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
SECTION B: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13C MEAL BENEFIT - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	Yes
SECTION B: #13C MEAL BENEFIT - BASE 3	

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

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access Technologies (including Web/Phone-based	Mandatory

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technologies and Nursing Hotline):

Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	100.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	100.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	100.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Every three months

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS

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	WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL. INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.
Fitness Benefit Notes:*	THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

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	THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME. VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.
Home and Bathroom Safety Devices and Modifications Notes:*	THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Alternative Therapies Notes:*	UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS. THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A

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

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

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

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

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

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

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

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

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

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

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

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	No

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Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

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

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SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	5000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5	
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6	
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES. FIXED DENTURES: UP TO 4 UNITS PER YEAR. RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE. IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS.

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	SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER. ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION. THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

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SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	1000.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types).	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #18B HEARING AIDS - BASE 5	
Is authorization required?	Yes
Is a referral required for Hearing Aids?	No
SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI	
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs

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Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RJ COMPONENT.
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	5092

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

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE

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Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY. ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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

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

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benefits?

How many packages do your Additional Benefits contain? (1-15)	2

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	73337
Expected Number of Enrollees to be engaged and receive Model benefits:	73337

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other) : 14e: Other Defined Supplemental Benefits

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

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

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

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	145.00
Select the package level maximum coverage periodicity:	Every month
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13i1: Food and Produce : 13i2: Meals (beyond limited basis) : 13i3: Pest Control : 13i6: Social Needs Benefit : 13i10: General Supports for Living : 13i-O1: Other 1 Non-Primarily Health Related Benefit : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications

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: 14c17. Alternative Therapies

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

Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORY 19B, SUCH AS: - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY) ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month

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

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

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

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

Notes:

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

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	ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Social Needs Benefit : General Supports for Living

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

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity.	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	MONTHLY ALLOWANCE.

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

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD.

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

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS.

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

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month

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

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL GROOMING SERVICES.

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

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for Living?	No

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND CLOTHING, HARDWARE ITEMS.

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

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

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

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

Enter name of Service:	PET CARE
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

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

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

Enter name of Service:	PERSONAL CARE ITEMS
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	145.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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Is a referral required for Other 2 Services?	No

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS.

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

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR: 1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS* 3. PEST CONTROL (1 PER QTR.) 4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.) 5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND EMR

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UNLIMITED REMOTE SUPPORT PER YR.)

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	Yes

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	145.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices	145.00

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and Modifications:	
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	145.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

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

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

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

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

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

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

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Fitness Benefit Notes:*	ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Home and Bathroom Safety Devices and Modifications Notes:*	MONTHLY ALLOWANCE. ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT

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	ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Alternative Therapies Notes:*	MONTHLY ALLOWANCE. UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

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

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	5092
Expected Number of Enrollees to be engaged and receive Model benefits:	1052

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

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

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

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

Is there a package level maximum coverage amount?	No

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

Notes:	NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):	NEW AND INNOVATIVE TECHNOLOGIES
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

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

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

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

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

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

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

SECTION B: #19C VBID HOSPICE- BASE 2

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

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Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?	Yes
SECTION D: REDUCTIONS IN COST SHARING - GENERAL	
Do you offer Reductions in Cost Sharing?	No
SECTION D: COMBINED BENEFITS - GENERAL	
Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	2
SECTION D: COMBINED BENEFITS #1	
Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies

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What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	100.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every three months
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies : 19b: Additional Benefits for VBID/UP/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	145.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:

COMBINED BENEFITS #1:
THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING

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

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

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

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Notes:

COMBINED BENEFITS #2:

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	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS. SUCH AS. - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)
SECTION RX: MEDICARE RX GENERAL 1	
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.
SECTION RX: MEDICARE RX GENERAL 2	
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No
SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY	
Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply

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

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 047, SEGMENT 0

Module:	PBP
Requested By:	rcqg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/01/2022 10:16:23 AM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 01:55:14 PM SA Western Standard Time
PD BPT Timestamp:	06/03/2022 02:50:08 PM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

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

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	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Marlcao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of	No

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discharge?	
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #2 SNF - BASE 6	
Is there an enrollee Copayment?	No
SECTION B: #2 SNF - BASE 10	

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What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

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

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

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

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

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

Is there an enrollee Copayment?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	Yes

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Coverage?	
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	500.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

Is there an enrollee Copayment?	No

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

Is authorization required?	Yes

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7d: Physician Specialist Services
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

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

Is there a service-specific Maximum Enrollee	No

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No

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Is authorization required?	Yes
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3	
Is authorization required?	Yes
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments

Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13A ACUPUNCTURE - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	100.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	; The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

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Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
SECTION B: #13B OTC ITEMS - BASE 3	
Notes:	THE FOLLOWING CATEGORIES ARE COVERED: 1) MINERALS AND VITAMINS 2) FIRST AID SUPPLIES 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS 4) MOUTH CARE 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS) 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
SECTION B: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes

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Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

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

SECTION B: #13C MEAL BENEFIT - BASE 3

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

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	100.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	100.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every three months

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

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Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	100.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Every three months

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES. EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL

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

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

Fitness Benefit Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

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

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ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Remote Access Technologies (Nursing Hotline) Notes:	THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.
Home and Bathroom Safety Devices and Modifications Notes:*	THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND

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

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

Alternative Therapies Notes:*	UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS. THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

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

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

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

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

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

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

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

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

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Diabetes Self-Management Training?	
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

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

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Services?	
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT

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COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

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

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

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

SECTION B: #17A EYE EXAMS - BASE 1

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

SECTION B: #17A EYE EXAMS - BASE 2

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

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

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Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every two years
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #18B HEARING AIDS - BASE 5	
Is authorization required?	Yes

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Is a referral required for Hearing Aids?	No

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance	: Electronic Health Records/Electronic Medical Records

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directives are connected from your program to access points of care.	: Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	1310

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

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY. ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR

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	LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	1310
Expected Number of Enrollees to be engaged and receive Model benefits:	271

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

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

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

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

Is there a package level maximum coverage amount?	No

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

Notes:	NEW AND INNOVATIVE TECHNOLOGIES

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

Enter name of Service (Optional):	NEW AND INNOVATIVE TECHNOLOGIES
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	18873
Expected Number of Enrollees to be engaged and receive Model benefits:	1887

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

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

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

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

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

Is there a package level maximum coverage amount?	No

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

Notes:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER

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

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

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

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR: 1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS*

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

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

SECTION B: #19C VBID HOSPICE- BASE 1	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%

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Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?	Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	1

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.
Is the enrollee limited to one or more of the	No

combined supplemental benefits from the package which they must select in advance?	
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	100.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every three months
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:

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

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE

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	COVERED FOR ALTERNATIVE THERAPIES: 1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
SECTION RX: MEDICARE RX GENERAL 1	
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.
SECTION RX: MEDICARE RX GENERAL 2	
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No
SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY	
Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing	: Standard Mail-Order - 3-month supply

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Location/supply amount(s) that apply:	
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	; Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: VBID - GENERAL

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

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 049, SEGMENT 0

Module:	PBP
Requested By:	rcqg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/01/2022 02:24:43 PM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 01:56:28 PM SA Western Standard Time
PD BPT Timestamp:	07/15/2022 10:29:30 AM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-I

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

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	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4003
Plan ID:	049
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of	No

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discharge?	
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #2 SNF - BASE 6	
Is there an enrollee Copayment?	No
SECTION B: #2 SNF - BASE 10	

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What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

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

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

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

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

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

Is there an enrollee Copayment?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	Yes

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Coverage?	
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	$00.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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Is there an enrollee Copayment?	No

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

Is authorization required?	Yes

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	; 7d: Physician Specialist Services
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

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

Is there a service-specific Maximum Enrollee	No

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

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Is there an enrollee Copayment?	No
SECTION B: #11A DME - BASE 2	
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes
Notes:	DME Supplies 0%, Wheelchair 5%, DME Hosp Bed 5%, DME Power Wheelchair 20%, All other DME 0%
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3	
Is authorization required?	Yes
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	

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Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
SECTION B: #13B OTC ITEMS - BASE 3	
Notes:	THE FOLLOWING CATEGORIES ARE COVERED: 1) MINERALS AND VITAMINS 2) FIRST AID SUPPLIES 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS 4) MOUTH CARE 5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS) 6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD

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	PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION. 7) FIBER SUPPLEMENTS 8) TOPICAL SUNSCREEN 9) SUPPORTING ITEMS FOR COMFORT 10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
SECTION B: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13C MEAL BENEFIT - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	Yes
SECTION B: #13C MEAL BENEFIT - BASE 3	

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

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies* : 14c21: In-Home Support Services*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access	Mandatory

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Technologies (including Web/Phone-based technologies and Nursing Hotline):	
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	50.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	50.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	50.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Every three months

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR [HGH] RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A

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

Fitness Benefit Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

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

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Remote Access Technologies (Nursing Hotline) Notes:

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

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

Home and Bathroom Safety Devices and Modifications Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:

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

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

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

Alternative Therapies Notes:*

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

THE MAXIMUM BENEFIT COVERAGE

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	AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
In-Home Support Services Notes:*	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE IN-HOME SUPPORT SERVICES BENEFIT, THEY WILL BE ELIGIBLE FOR UP TO 4-HOUR IN-HOME CARE VISITS (UP TO 12 HRS. PER QUARTER, FOR A MAXIMUM AMOUNT OF 48 HRS. TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY LIVING. PA MAY APPLY.

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

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

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

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

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

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

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

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

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

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

Barium Enemas?	
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

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

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Other Oral/Maxillofacial Surgery, Other Services:	
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5	
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6	
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH. PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

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FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

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

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

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

SECTION B: #17A EYE EXAMS - BASE 1

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

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1

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Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every three years
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #18B HEARING AIDS - BASE 5	
Is authorization required?	Yes
Is a referral required for Hearing Aids?	No
SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI	

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Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals

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Expected Number of Beneficiaries to be Engaged Annually:	213

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

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY. ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING

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	CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

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

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

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

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

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

Targeting Methodology - Please choose one or both:	; Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	3073
Expected Number of Enrollees to be engaged and receive Model benefits:	3073

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

Is there a prerequisite for reduction of cost sharing for this package?	No
Does the plan reduce cost sharing to $0 for all covered benefits, up to a maximum aggregate amount?	No
Select the benefits that apply to reduced cost sharing:	: Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

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

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

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

Do you offer reduced Coinsurance?	Yes
Select the types of benefits that apply to the	: Medicare-covered benefits

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coinsurance cost sharing:

Select the Medicare-covered benefits that will receive reduced coinsurance:	: 11a: Durable Medical Equipment (DME) : 1161: Prosthetic Devices : 1162: Medical Supplies

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

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

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

Do you offer a reduced deductible amount?	No

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

Do you offer reduced Copayment?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a maximum aggregate amount of reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	180.00

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

Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

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

benefits?

How many packages do your Additional Benefits contain? (1-15)	3

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	3073
Expected Number of Enrollees to be engaged and receive Model benefits:	3073

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other) : 14c: Other Defined Supplemental Benefits

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

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

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

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	180.00
Select the package level maximum coverage periodicity:	Every month
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13i1: Food and Produce : 13i2: Meals (beyond limited basis) : 13i3: Pest Control : 13i6: Social Needs Benefit : 13i10: General Supports for Living : 13i-O1: Other 1 Non-Primarily Health Related Benefit : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications

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: [4c] 7: Alternative Therapies

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

Notes:	EMBEDDED SUPPLEMENTAL BENEFITS: MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B, SUCH AS: - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY) FLEXIBLE SUPPLEMENTAL BENEFITS: ADDITIONAL MONTHLY ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH. EMBEDDED SUPPLEMENTAL BENEFITS: ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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

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

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Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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

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

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

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQU[illegible] MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFOR[illegible]

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	10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) 12) PERSONAL HYGIENE PRODUCTS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Social Needs Benefit : General Supports for Living

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

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

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

Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL GROOMING SERVICES. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00

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Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND CLOTHING, HARDWARE ITEMS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #131 NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2 : Other 3

SECTION B: VBID/UF/SSBCI 19B #131 OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PET CARE
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #131 OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

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

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Is a referral required for Other 1 Services?	No

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Enter name of Service:	PERSONAL CARE ITEMS
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	180.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

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

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan	Yes

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Benefit Coverage amount?	
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:

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

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

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

IN ADDITION, MEMBER CAN USE THE $180 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT:

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	ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	Yes

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	180.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	180.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

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

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	180.00

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Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

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

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

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

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

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

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

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Fitness Benefit Notes:*	ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

Home and Bathroom Safety Devices and Modifications Notes:*	MONTHLY ALLOWANCE. ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT

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	CARD OF $50 PER MONTH.

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

Alternative Therapies Notes:*	MONTHLY ALLOWANCE. UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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

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

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

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	213
Expected Number of Enrollees to be engaged and receive Model benefits:	44

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

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

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

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

Is there a package level maximum coverage amount?	No

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

Notes:	NEW AND INNOVATIVE TECHNOLOGIES

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

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

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Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	3073
Expected Number of Enrollees to be engaged and receive Model benefits:	3073

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level	No

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deductible?

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

Is there a package level maximum coverage amount?	No

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

Notes:	UPON SELECTION OF THE VBID BENEFIT, THE MEMBER WILL BE ELIGIBLE BASED ON LOW INCOME STATUS QUALIFICATION FOR THE DUAL ELIGIBLE SPECIAL NEEDS PLAN. THE BENEFITS ARE INTENDED TO ENHANCE THE QUALITY OF CARE FOR MEDICARE BENEFICIARIES AND/OR IMPROVE THE COORDINATION AND EFFICIENCY OF HEALTH CARE SERVICE DELIVERY AS WELL AS REASONABLE EXPECTATIONS THAT THE ENROLLEES HEALTH OR OVERALL FUNCTION WILL IMPROVE OR BE MAINTAINED BY ACCESS TO THE BENEFIT.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #3

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : General Supports for Living

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

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #3

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

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

Notes:	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE FOOD AND PRODUCE BENEFIT, THEY WILL BE ELIGIBLE FOR 1 HEALTHY FOOD BOX A MONTH.

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SECTION B: VBID/UF/SSBCI 19D #131 MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #3

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #131 MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #3

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

SECTION B: VBID/UF/SSBCI 19B #131 MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #3

Notes:	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE MEALS (BEYOND LIMITED BASIS), THEY WILL BE ELIGIBLE FOR UP TO 45 FROZEN MEALS PER QUARTER, FOR A MAXIMUM AMOUNT OF 180 FROZEN MEALS A YEAR.

SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #3

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #131 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #3

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for	No

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Living?

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

Notes:	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE SMARTPHONE BENEFIT, THEY WILL RECEIVE ONE SMARTPHONE WITH A VOICE AND DATA PLAN WHILE ENROLLED IN THE PLAN. THE MEMBER WILL HAVE TO RETURN THE SMARTPHONE TO THE MAO IN CASE OF DISENROLLMENT OR CHANGE IN PLAN COVERAGE.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #3

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1

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

Enter name of Service:	ADDITIONAL ALLOWANCE FOR DEBIT CARD
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE ADDITIONAL ALLOWANCE FOR DEBIT CARD, THEY WILL BE ELIGIBLE FOR UP TO $50 PER MONTH. MEMBER WILL BE ABLE TO USE THE DEBIT CARD FOR THE FOLLOWING SERVICES:

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1. MEALS (BEYOND LIMITED BASIS)- PREPARED FOOD
2. FOOD AND PRODUCE- FOOD & GROCERIES
3. GENERAL SUPPORT FOR LIVING- GASOLINE
4. PEST CONTROL- CLEANING PRODUCTS
5. SOCIAL NEEDS BENEFITENTERTAINMENT (CONCERTS/THEATER/MOVIES, ETC)
6. GENERAL SUPPORT FOR LIVING- UTILITIES
7. OVER-THE-COUNTER (OTC) ITEMS- ADDITIONAL OTC ITEMS
8. ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
9. HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS
10. PART C COPAYMENTS/COINSURANCE
11. NON-PRIMARILY HEALTH RELATED (OTHER)- PET CARE
12. GENERAL SUPPORTS FOR LIVING- GARDENING/HARDWARE ITEMS
13. NON-PRIMARILY HEALTH RELATED (OTHER)- PERSONAL CARE SERVICES, SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES (MANICURE, PEDICURE, HAIRCUT, ETC.), HAIR GROWTH AND ANTI-AGING/SPOT CREAMS
14. GENERAL SUPPORTS FOR LIVING- HOME APPLIANCES
15. GENERAL SUPPORTS FOR LIVING- TOWELS, LINENS AND CLOTHING
16. NON-PRIMARILY HEALTH RELATED (OTHER)- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
17. FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION B: #19C VBID HOSPICE- BASE 1	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription	5%

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drugs and biologics:	
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits

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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	Yes
How many groups of Reductions in Cost Sharing are you offering?	1

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 1

Select the benefits that apply to the Reductions in Cost Sharing benefit:	: Medicare-covered benefits
Select which Medicare-Covered Services your Reductions in Cost Sharing apply to:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 2

Indicate Max Plan Benefit amount:	180.00
Select Reductions in Cost Sharing periodicity:	Every month
Can the reduction in cost sharing be applied to a deductible?	No
What is your Reductions in Cost Sharing mode of delivery?	: Debit Card
Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES IN THE COMBINED PACKAGE. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	3

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.

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Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	50.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every three months
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 14c21: In-Home Support Services : 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card : Other
Other Description:	DIRECT PAYMENT TO VENDOR
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	Yes
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	50.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #3

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies : 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	180.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

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SECTION D: NOTES

Notes:

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

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS

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3) PUZZLES FOR MEMORY FITNESS

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

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Notes:

COMBINED BENEFITS #2:
MEMBERS SELECT TWO (2) OF THE FOLLOWING FLEX BENEFITS REFERENCED IN THE APPLICABLE SECTION B SUBCATEGORIES:
1) 14C21: IN-HOME SUPPORT SERVICES, AND/OR
2) 19B-13I: GENERAL SUPPORTS FOR LIVING, AND/OR
3) 19B-13I: FOOD AND PRODUCE, AND/OR
4) 19B-13I: MEALS (BEYOND LIMITED BASIS), AND/OR
5) 19B-13I-OTHER: ADDITIONAL ALLOWANCE FOR DEBIT CARD

COMBINED BENEFITS #3:
MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS, SUCH AS.
- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)

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	- HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)
SECTION RX: MEDICARE RX GENERAL 1	
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.
SECTION RX: MEDICARE RX GENERAL 2	
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No
SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY	
Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the	No

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SECTION RX: VBID - GENERAL

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

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4003, PLAN 058, SEGMENT 0

Module:	PBP
Requested By:	reqg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/01/2022 10:18:26 AM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 02:18:52 PM SA Western Standard Time
PD BPT Timestamp:	06/03/2022 02:57:12 PM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

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SECTION A: SECTION A-1

Organization Legal Name:	MMM HEALTHCARE, LLC
Organization Marketing Name:	Medicare y Mucho Mas
Organization Web Site:	www.mmmpr.com
Plan Name:	MMM Dorado Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40710 - Utuado, PR
Contract Number:	H4003
Plan ID:	058
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico Northwest
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for	(866)333-5471

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Current Medicare Beneficiaries:	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE I	

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

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

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

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

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

SECTION B: #2 SNF - BASE 1

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

SECTION B: #2 SNF - BASE 2

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

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

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

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

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

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

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

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

SECTION B: #4A EMERGENCY SERVICES - BASE 1

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

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

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

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

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

Is there an enrollee Copayment?	No

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

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	500.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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Is a referral required for Chiropractic Services?	Yes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost?	
SECTION B: #7F PODIATRY SERVICES - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7F PODIATRY SERVICES - BASE 3	
Is authorization required?	Yes
Is a referral required for Podiatrist Services?	Yes
SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2	
Is authorization required?	Yes
Is a referral required for Other Health Care Professional Services?	Yes
SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3	
Is authorization required?	Yes
Is a referral required for Psychiatric Services?	Yes
SECTION B: #7I PT AND SP SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7I PT AND SP SERVICES - BASE 2	
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1	
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7d: Physician Specialist Services

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

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

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

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No

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

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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

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

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

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

SECTION B: #11A DME - BASE 1

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No
Is authorization required?	Yes

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

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

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

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

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

Is authorization required?	Yes

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

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

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

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

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Acupuncture?	Yes
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	35.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT)	: The Nicotine Replacement Therapy (NRT)

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Attestation:	being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

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

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

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	CATEGORY MAY APPLY.
SECTION B: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13C MEAL BENEFIT - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	Yes
SECTION B: #13C MEAL BENEFIT - BASE 3	
Notes:	POST DISCHARGE 2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX PER YEAR.
SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES	
Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	Yes
Is a referral required?	No
SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1	
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1	
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including

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	Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	35.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	35.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Every three months

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

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	35.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Every three months

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES

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

Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:

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

Fitness Benefit Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

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

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

Remote Access Technologies (Nursing Hotline) Notes:

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

Home and Bathroom Safety Devices and Modifications Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:

1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD

4) REACHER
5) NIGHTLIGHT

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

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

Alternative Therapies Notes:*	UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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

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

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

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

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

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

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

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

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

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

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

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Services:	
Select the Restorative Services periodicity:	Other, Describe
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2	
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5	
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6	
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING

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SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES (SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

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

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

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

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SECTION B: #17A EYE EXAMS - BASE I

Does the plan provide Eye Exams as a

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supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	750.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	

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Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every three years
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #18B HEARING AIDS - BASE 5	
Is authorization required?	Yes
Is a referral required for Hearing Aids?	No
SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI	
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs
Value-Based Insurance Design Attestation	: I attest that
SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING	
WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE

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	REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	116

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

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART TIIAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES

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	DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY. ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY). INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

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

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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

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

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

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

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

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	1667
Expected Number of Enrollees to be engaged and receive Model benefits:	1667

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 13i-O: Non-Primarily Health Related Benefits

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	for the Chronically Ill (Other) : 14c: Other Defined Supplemental Benefits

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

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

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

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	325.00
Select the package level maximum coverage periodicity:	Every month
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13i1: Food and Produce : 13i2: Meals (beyond limited basis) : 13i3: Pest Control : 13i6: Social Needs Benefit : 13i10: General Supports for Living : 13i-O1: Other 1 Non-Primarily Health Related Benefit : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies

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

Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORY 19B, SUCH AS: - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY

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	DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY) ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED: 1) MINERALS AND VITAMINS 2) FIRST AID SUPPLIES

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3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)
12) PERSONAL HYGIENE PRODUCTS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #131 NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill Includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Social Needs Benefit : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #131 FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #131 FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:	MONTHLY ALLOWANCE.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for the Meals (beyond limited basis)?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL GROOMING SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #1

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

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Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for Living?	No

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND CLOTHING. HARDWARE ITEMS.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2 : Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PET CARE
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 1 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED

BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PERSONAL CARE ITEMS
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	325.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 3 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR)
2. IN-HOME MINOR REPAIRS*
3. PEST CONTROL (1 PER QTR.)
4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE, GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.)
5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF $300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS

IN ADDITION, MEMBER CAN USE THE $325 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIS AND OTHER SERVICES.

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness

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Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	Yes

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	325.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	325.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	325.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Fitness Benefit Notes:*	ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	MONTHLY ALLOWANCE. ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*	MONTHLY ALLOWANCE. UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	116

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Expected Number of Enrollees to be engaged and receive Model benefits:	24

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional):	NEW AND INNOVATIVE TECHNOLOGIES
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	Yes

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SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes:	THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED FOR DETECTING TRENDS AND TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes

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Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate	Lower

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or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?	Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	2

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	35.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every three months
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies : 19b: Additional Benefits for VBID/UF/SSBCI

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What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	325.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:

COMBINED BENEFITS #1:
THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD

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4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Notes:

COMBINED BENEFITS #2:
MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS, SUCH AS.
- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL. (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS
- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES

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	- PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: VBID - GENERAL

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Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	**No**

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 048, SEGMENT 0

Module:	**PBP**
Requested By:	**rcqg**

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/01/2022 12:33:19 PM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 12:45:22 PM SA Western Standard Time
PD BPT Timestamp:	06/03/2022 02:57:42 PM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

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Organization Legal Name:	MMM HEALTHCARE, LLC
Organization Marketing Name:	PMC Medicare Choice
Organization Web Site:	www.mmmpr.com
Plan Name:	PMC Premier Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	

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Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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Service Area(s):	40750 - Villalba, PR 40760 - Yabucoa, PR 40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	048
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note. Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of	No

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discharge?	
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #2 SNF - BASE 6	
Is there an enrollee Copayment?	No
SECTION B: #2 SNF - BASE 10	

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What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	Yes

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	Yes

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Coverage?	
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	500.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	Yes
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits.	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Podiatrist Services?	Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

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Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Psychiatric Services?	Yes

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7d: Physician Specialist Services
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes

Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Substance Abuse?	Yes

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No

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Is authorization required?	Yes
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3	
Is authorization required?	Yes
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	Yes
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00

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Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Acupuncture?	Yes
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
SECTION B: #13B OTC ITEMS - BASE 3	
Notes:	THE FOLLOWING CATEGORIES ARE COVERED: 1) MINERALS AND VITAMINS 2) FIRST AID SUPPLIES 3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS

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4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE
(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #13C MEAL BENEFIT - BASE I

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	Yes
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	POST DISCHARGE 2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX PER YEAR.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	Yes
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies* : 14c21: In-Home Support Services*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9

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Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Select type of benefit for In-Home Support Services:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	200.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	200.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	200.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost for Other Defined Supplemental Benefits?	

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?	Yes
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE

OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.

Fitness Benefit Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes:

THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH

PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS.
3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.

Home and Bathroom Safety Devices and Modifications Notes:*

THE FOLLOWING ITEMS WILL BE COVERED:

1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

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THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*	UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS. THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.
In-Home Support Services Notes:*	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE IN-HOME SUPPORT SERVICES BENEFIT, THEY WILL BE ELIGIBLE FOR UP TO 4-HOUR IN-HOME CARE VISITS (UP TO 24 HRS. PER QUARTER, FOR A MAXIMUM AMOUNT OF 96 HRS. TOTAL PER YEAR) TO HELP WITH ACTIVITIES OF DAILY LIVING. PA MAY APPLY.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	No

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Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other	Mandatory

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Oral/Maxillofacial Surgery, Other Services:	
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5	
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6	
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES

(SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL, RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS.
SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED. CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

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SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid

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Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	

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Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	Yes
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.

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Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	687

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY.

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	ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	3

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	9893
Expected Number of Enrollees to be engaged and receive Model benefits:	9893

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13b: Over-the-Counter (OTC) Items : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other) : 14c: Other Defined Supplemental Benefits

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	65.00
Select the package level maximum coverage periodicity:	Every month
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13i1: Food and Produce : 13i2: Meals (beyond limited basis) : 13i3: Pest Control : 13i6: Social Needs Benefit : 13i10: General Supports for Living : 13i-O1: Other 1 Non-Primarily Health Related Benefit : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	EMBEDDED SUPPLEMENTAL BENEFITS: MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORY 19B, SUCH AS: - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES

- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

FLEXIBLE SUPPLEMENTAL BENEFITS: ADDITIONAL MONTHLY ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

EMBEDDED SUPPLEMENTAL BENEFITS: ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

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SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:	THE FOLLOWING HEALTH & NON

HEALTH RELATED CATEGORIES ARE COVERED:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)
12) PERSONAL HYGIENE PRODUCTS

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Social Needs Benefit : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

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Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13] FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13] FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13] MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13] MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for the Meals (beyond limited basis)?	No

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SECTION B: VBID/UF/SSBCI 19B #13] MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:	2 MEALS PER DAY, FOR 10 DAYS, UP TO 1

	TIME PER YEAR, FOR 20 MEALS MAX PER YEAR. ALSO INCLUDES A MONTHLY ALLOWANCE FOR THE PURCHASE OF PREPARED FOOD / ADDITIONAL MEALS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL GROOMING SERVICES. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19D #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #1

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for Living?	No

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME APPLIANCES, TOWELS / LINENS AND

	CLOTHING, HARDWARE ITEMS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2 : Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PET CARE
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	65.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 1 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PERSONAL CARE ITEMS
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage	65.00

amount:	
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 3 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	EMBEDDED SUPPLEMENTAL BENEFIT:

MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR:

1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR)
2. IN-HOME MINOR REPAIRS*
3. PEST CONTROL (1 PER QTR)
4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.)
5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF $300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE $65 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

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Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	Yes

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	65.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	65.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	65.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined	No

Supplemental Benefits?	
Fitness Benefit Notes:*	ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	MONTHLY ALLOWANCE. ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*	MONTHLY ALLOWANCE. UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY. FLEXIBLE SUPPLEMENTAL BENEFIT: ADDITIONAL ALLOWANCE FOR DEBIT CARD OF $50 PER MONTH.

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	687
Expected Number of Enrollees to be engaged and receive Model benefits:	142

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional):	NEW AND INNOVATIVE TECHNOLOGIES
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	Yes

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes:	THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED FOR DETECTING TRENDS AND TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW

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	THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #3

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #3

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	9893
Expected Number of Enrollees to be engaged and receive Model benefits:	9893

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #3

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #3

Is there a package level maximum coverage amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes:	UPON SELECTION OF THE VBID BENEFIT, THE MEMBER WILL BE ELIGIBLE BASED ON LOW INCOME STATUS QUALIFICATION FOR THE DUAL ELIGIBLE SPECIAL NEEDS PLAN. THE BENEFITS ARE INTENDED TO ENHANCE THE QUALITY OF CARE FOR MEDICARE BENEFICIARIES AND/OR IMPROVE THE COORDINATION AND EFFICIENCY OF HEALTH CARE SERVICE DELIVERY AS WELL AS REASONABLE EXPECTATIONS THAT THE ENROLLEES HEALTH OR OVERALL FUNCTION WILL IMPROVE OR BE MAINTAINED BY ACCESS TO THE BENEFIT.

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SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #3

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #3

Enter name of Service:	ADDITIONAL ALLOWANCE FOR DEBIT CARD
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	$0.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #3

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 1 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #3

Notes:	FLEXIBLE SUPPLEMENTAL BENEFITS: IF MEMBER SELECTS THE ADDITIONAL ALLOWANCE FOR DEBIT CARD, THEY WILL BE ELIGIBLE FOR UP TO $50 PER MONTH. MEMBER WILL BE ABLE TO USE THE DEBIT CARD FOR THE FOLLOWING SERVICES: 1. MEALS (BEYOND LIMITED BASIS)-PREPARED FOOD 2. FOOD AND PRODUCE- FOOD & GROCERIES 3. GENERAL SUPPORT FOR LIVING-GASOLINE 4. PEST CONTROL- CLEANING PRODUCTS 5. SOCIAL NEEDS BENEFITENTERTAINMENT (CONCERTS/THEATER/MOVIES, ETC) 6. GENERAL SUPPORT FOR LIVING-UTILITIES

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7. OVER-THE-COUNTER (OTC) ITEMS-ADDITIONAL OTC ITEMS
8. ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
9. HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS
10. PART C COPAYMENTS/COINSURANCE
11. NON-PRIMARILY HEALTH RELATED (OTHER)- PET CARE
12. GENERAL SUPPORTS FOR LIVING-GARDENING/HARDWARE ITEMS
13. NON-PRIMARILY HEALTH RELATED (OTHER)- PERSONAL CARE SERVICES, SUCH AS: PERSONAL HYGIENE PRODUCTS, GROOMING SERVICES (MANICURE, PEDICURE, HAIRCUT, ETC.), HAIR GROWTH AND ANTI-AGING/SPOT CREAMS
14. GENERAL SUPPORTS FOR LIVING-HOME APPLIANCES
15. GENERAL SUPPORTS FOR LIVING-TOWELS, LINENS AND CLOTHING
16. NON-PRIMARILY HEALTH RELATED (OTHER)- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
17. FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

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SECTION B: #19C VBID HOSPICE- BASE 2	
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5
SECTION B: #19C VBID HOSPICE- BASE 3	
Are you offering hospice supplemental benefits?	No
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?	Yes
SECTION D: REDUCTIONS IN COST SHARING - GENERAL	
Do you offer Reductions in Cost Sharing?	No
SECTION D: COMBINED BENEFITS - GENERAL	
Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes

Select the number of Combined Supplemental Benefit packages you are offering?	3

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	200.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 14c21: In-Home Support Services : 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card : Other
Other Description:	DIRECT PAYMENT TO VENDOR
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	Yes
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	50.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #3

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies

	: 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	65.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:

COMBINED BENEFITS #1:
THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT

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3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Notes:

COMBINED BENEFITS #2:
MEMBERS SELECT ONE (1) OF THE FOLLOWING FLEX BENEFITS REFERENCED IN THE APPLICABLE SECTION B SUBCATEGORIES:
1) 14C21: IN-HOME SUPPORT SERVICES, AND/OR
2) 19B-13]-OTHER: ADDITIONAL ALLOWANCE FOR DEBIT CARD

COMBINED BENEFITS #3:
MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS, SUCH AS.
- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)

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	- PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90

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Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No
SECTION RX: VBID - GENERAL	
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H4004, PLAN 062, SEGMENT 0

Module:	PBP
Requested By:	rcqg

PLAN SYSTEM INFORMATION

Last entry Date:	06/03/2022
PBP Software Version:	2023.01
Plan Ready for Upload Timestamp:	06/03/2022 11:42:19 AM SA Western Standard Time
MA BPT Timestamp:	07/14/2022 02:21:50 PM SA Western Standard Time
PD BPT Timestamp:	07/15/2022 10:29:30 AM SA Western Standard Time
Last Upload File Creation Timestamp:	07/15/2022 01:39:34 PM SA Western Standard Time
Upload Status:	07/15/2022 #02983

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

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Organization Legal Name:	MMM HEALTHCARE, LLC
Organization Marketing Name:	PMC Medicare Choice
Organization Web Site:	www.mmmpr.com
Plan Name:	MMM Relax Platino (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	

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Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H4004
Plan ID:	062
Segment ID:	0
Contract Period:	2023
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.mmmpr.com
Formulary Website Address:	www.mmmpr.com
Physician Website Address:	www.mmmpr.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)333-5471
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)333-5471
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2396
Customer Service Contact TTY for Current	(711)-

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Medicare Beneficiaries:	
Customer Service Contact Local TTY for Current Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Prospective Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact Local TTY for Current Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Prospective Part D Medicare Beneficiaries:	(711)-
Customer Service Contact TTY for Current Part D Medicare Beneficiaries:	(711)-
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of	No

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discharge?	
Is authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #2 SNF - BASE 6	
Is there an enrollee Copayment?	No
SECTION B: #2 SNF - BASE 10	

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What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	Yes

SECTION B: #4A EMERGENCY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage.	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent	Yes

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Coverage?	
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	500.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Worldwide Services have a Copayment (Select all that apply):	: Worldwide Emergency Coverage : Worldwide Urgent Coverage
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$75.00
Is this Copayment waived for Worldwide Emergency Coverage if admitted to hospital?	Yes
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$75.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$75.00
Is this Copayment waived for Worldwide Urgent Coverage if admitted to hospital?	Yes
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	Yes

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1	
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	750.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	Yes
Is a referral required for Chiropractic Services?	Yes
SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2	
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes
SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	Yes

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	6
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Podiatrist Services?	Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	Yes

Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Psychiatric Services?	Yes

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7d: Physician Specialist Services
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	No
Notes:	ADDITIONAL TELEHEALTH SERVICES COVERED FOR SPECIALIST SERVICES PROVIDED IN THE MULTI SPECIALTY CLINICS.

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee	No

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Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes

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Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Substance Abuse?	Yes

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	Yes
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	: Taxi : Rideshare Services : Bus/Subway : Van

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	No

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Is authorization required?	Yes
Notes:	DME Supplies 0%, Wheelchair 0%, DME Hosp Bed 10%, DME Power Wheelchair 0%, All other DME 0%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	20%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	20%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	No
Is authorization required?	Yes

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Dialysis Services?	No

SECTION B: #13A ACUPUNCTURE - BASE 1

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Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	500.00
Select Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Acupuncture?	Yes
SECTION B: #13B OTC ITEMS - BASE 1	
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	60.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
SECTION B: #13B OTC ITEMS - BASE 2	
Is there an enrollee Coinsurance?	No

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

THE FOLLOWING CATEGORIES ARE COVERED:

1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE
(FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) AND HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C?	Yes

Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	
Select type of benefit for Meals:	Mandatory
Select the type of primarily health related meals benefit offered:	: Immediately following surgery or inpatient hospitilization
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13C MEAL BENEFIT - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for the Meal Benefit?	Yes

SECTION B: #13C MEAL BENEFIT - BASE 3

Notes:	POST DISCHARGE 2 MEALS PER DAY FOR 5 DAYS UP TO 2 TIMES PER YEAR FOR 20 MEALS MAX PER YEAR.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	Yes
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 14c3: Additional Sessions of Smoking and Tobacco Cessation Counseling : 14c4: Fitness Benefit* : 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*

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Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Both Sessions (Individual and Group)
Select type of benefit for Additional Sessions of Smoking and Tobacco Cessation Counseling:	Mandatory
Indicate number of visits offered in addition to Medicare:	9
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	: Nursing Hotline
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	60.00
Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Every three months

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	60.00
Select Maximum Plan Benefit Coverage	Every three months

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periodicity for Home and Bathroom Safety Devices and Modifications:	
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6	
Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	60.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Every three months
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10	
Is there an enrollee Coinsurance?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14	
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	THE HEALTH EDUCATION PROGRAM DEVELOPS AND IMPLEMENTS EDUCATIONAL INTERVENTIONS BASED ON DIAGNOSIS SUCH AS DIABETES, HYPERTENSION MANAGEMENT AND PROVIDES NUTRITIONAL EDUCATION TO PROVIDE HEALTH INFORMATION ENCOURAGING MEMBERS TO ADOPT A HEALTHIER LIFESTYLE AND DEVELOP SELF CARE CAPABILITIES TO IMPROVE THE MEMBER'S HEALTH. SCOPE: IDENTIFY THE POPULATION WITH EDUCATIONAL NEEDS, PLAN EDUCATIONAL STRATEGIES, PROMOTION OF HEALTHY LIFESTYLE AND PREVENTION OF COMPLICATIONS.IMPLEMENT AND CARRY OUT EDUCATIONAL STRATEGIES, EVALUATE THE RESULTS AND CREATE FUTURE GOALS.INTERVENTIONS MIGHT INCLUDE:EDUCATIONAL CAMPAIGNS, MEMBER EDUCATIONAL ACTIVITIES INCLUDING GROUP SESSIONS WHERE EDUCATORS PROVIDE INFORMATION TO IMPROVE THE MEMBER'S SKILL SETS.THE HEP HAS ALSO INDIVIDUAL

	INTERVENTIONS BASED FOR HIGH RISK CASES. THE PROGRAM DISTRIBUTES NEWSLETTERS WITH HEALTH RELATED INFORMATION, AND HAS PHYSICAL ACTIVITY AWARENESS AND ONLINE ACCESS TO EDUCATIONAL LITERATURE AS PART OF THE EDUCATIONAL INTERVENTIONS.
Additional Sessions of Smoking and Tobacco Cessation Counseling Notes:	THE SMOKING CESSATION PROGRAM ROMPE EL HABITO HAS THE PURPOSE OF IMPACTING MEMBERS WHO USE SOME FORM OF TOBACCO BASED ON THE CLIENT APPROACHED MODEL AND THE TRANSTHEORETICAL MODEL THAT DESCRIBES HOW PEOPLE MODIFY A PROBLEM BEHAVIOR OR ACQUIRE A POSITIVE BEHAVIOR. OBJECTIVE: TO DIMINISH THE RISK FACTORS TO PREVENT ASSOCIATED ILLNESSES UPON SMOKING. IS AVAILABLE FOR MEMBERS WHO USE OR SMOKE TOBACCO AND/OR STOP SMOKING DURING THE LAST 12 MONTHS. THE MAIN GOAL IS TO EMPOWER THEM TO QUIT THE PROCESS BY PROVIDING INF AND SUPPORT SERVICES TO HELP THEM ESTABLISH A QUIT DATE, REDUCE QUANTITY OF CIGARETTE USE PER DAY, AND/OR STOP SMOKING. THE MAIN INTERVENTIONS ARE: ASSESSMENT CALLS, TEL INTERVENTIONS REGARDING QUIT AND/OR RELAPSE PREVENTION, EDUCATIONAL MATERIALS, AVAILABILITY OF THE SUPPORT GROUP, MED EDUCATION, F/UP INTERVENTIONS, AMONG OTHERS. TO PREVENT A RELAPSE PHASE, INTERVENTIONS TO IMPROVE THE PARTICIPANT'S COMPLIANCE WITH THEIR PHYSICIAN'S PHARMACOLOGICAL TREATMENT PLAN ARE OFFERED.
Fitness Benefit Notes:*	THE FOLLOWING ITEMS WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE

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	THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes:	THE NURSE TRIAGE LINE IS AVAILABLE 24/7 TO THE MEMBERS. HEALTH PROFESSIONALS ANSWER MEMBER CALLS AND DETERMINE THE SEVERITY OF THE CALLER'S COMPLAINT USING A SERIES OF ALGORITHMS BASED BY THE AMERICAN MEDICAL ASSOCIATION AND CLINICAL GUIDELINES. THE HEALTH PROFESSIONALS WILL RECOMMEND ACTIONS TO THE CALLER BASED ON TRIAGE PROTOCOLS THAT CAN INCLUDE: 1. DIRECT THE CALLER TO THE APPROPRIATE USE OF MEDICAL RESOURCES AS: INITIAL TREATMENT AT HOME, VISIT TO THE PRIMARY CARE PHYSICIAN IN THE NEXT FEW DAYS OR VISIT TO EMERGENCY ROOM IF NECESSARY ACCORDING WITH THE SIGN AND SYMPTOMS PRESENTED. 2. CHANNELING OF THE OTHERS SERVICES AS: MENTAL HEALTH, POISON CONTROL AMONG OTHERS. 3. DIRECT ACCESS TO THE 911 EMERGENCY LINES, CRISIS MANAGEMENT LINES, EMERGENCY ROOMS, OR HMO'S SYSTEMS. 4. PROVIDE EDUCATION REGARDING THE SYMPTOMS AND MANAGEMENT OF MEDICAL EMERGENCIES, LABORATORY TEST, MEDICAL PRESCRIPTIONS, MEDICATION USE, CHRONIC CONDITIONS, NUTRITION, PSYCOLOGIC HELP AND OTHERS CLINICAL AREAS.
Home and Bathroom Safety Devices and Modifications Notes:*	THE FOLLOWING ITEMS WILL BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT THIS IS A COMBINED BENEFIT WITH A

	SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:*	UNDER THIS CATEGORY WE WILL COVER NATUROPATH VISITS AND ALSO HOMEOPATHIC/NATURAL MEDICINE ITEMS. THE MAXIMUM BENEFIT COVERAGE AMOUNT WILL ONLY APPLY FOR HOMEOPATHIC/NATURAL MEDICINE ITEMS. THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	No

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Is authorization required for Medicare-covered Glaucoma Screening?	Yes
Is authorization required for Medicare-covered Diabetes Self-Management Training?	Yes
Is authorization required for Medicare-covered Barium Enemas?	Yes
Is authorization required for Medicare-covered Digital Rectal Exams?	Yes
Is authorization required for Medicare-covered EKG following Welcome Visit?	Yes

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Restorative Services : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Prosthodontics, Other	Mandatory

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Oral/Maxillofacial Surgery, Other Services:	
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5	
Is there an enrollee Copayment?	No
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6	
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Restorative Services Notes:	CORE BUILDUP AND PIN RETENTION PER TOOTH, PER SURFACE, ONCE EVERY 24 MONTHS. POST AND CORE AND SINGLE CROWNS COVERED. REPLACEMENT CROWNS COVERED EVERY 5 YEARS PER TOOTH. SINGLE CROWNS REQUIRE PRE AUTHORIZATION.
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services Notes:	PROSTHODONTIC SERVICES: REMOVABLE COMPLETE OR PARTIAL DENTURES IN RESIN AND METAL BASE, COVERED EVERY 5 YEARS. DENTURE REPAIR SERVICES, INCLUDING SERVICES RELATED TO THE REPAIR OF EXISTING COMPLETE OR PARTIAL DENTURES ARE COVERED. REMOVABLE PARTIAL FLEXIBLE BASE DENTURES

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(SUCH AS: VALPLAST) COVERED EVERY 5 YEARS. RELINE OR REBASE ARE NOT COVERED IN FLEXIBLE BASE DENTURES AND/OR FLEXIBLE BASE ARE NOT COVERED IN COMPLETE OR FULL DENTURES.

FIXED DENTURES: UP TO 4 UNITS PER YEAR.
RETAINER CROWN PORCELAIN FUSED TO HIGH NOBLE METAL. RETAINER CROWN PORCELAIN/CERAMIC, PONTIC PORCELAIN FUSED TO NOBLE AND/OR HIGH NOBLE METAL, PONTIC PORCELAIN/ CERAMIC. PONTICS AND RETAINERS ARE COVERED 1 PER TOOTH PER LIFE.

IMPLANTS: UP TO 2 IMPLANTS A YEAR OR 4 IMPLANTS A YEAR FOR EDENTULOUS PATIENTS.
SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT, COVERED ONE PER TOOTH PER LIFE. ABUTMENT SUPPORTED PORCELAIN (METAL AND/OR HIGH NOBLE METAL), ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN, IMPLANT SUPPORTED PORCELAIN CROWN (CERAMIC) COVERED CROWNS ON IMPLANTS ARE COVERED 1 PER TOOTH EVERY 5 YEARS WITH APPROPRIATE JUSTIFICATION. IMPLANT SERVICES WILL ONLY BE COVERED WHEN PERFOMED BY A CERTIFIED PROVIDER.

ALL OTHER PROSTHODONTIC SERVICES ARE NOT COVERED. REMOVABLE PROSTHODONTICS, FIXED DENTURES, IMPLANTS AND RETAINER CROWNS REQUIRE PRE AUTHORIZATION.

THE MAXIMUM PLAN BENEFIT COVERAGE AMOUNT WILL APPLY FOR ALL COMPREHENSIVE SERVICES.

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SECTION B: #17A EYE EXAMS - BASE I

Does the plan provide Eye Exams as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	Yes
Is a referral required for Eye Exams?	No
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames)
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Fitting/Evaluation for Hearing Aid

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Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Hearing Exams?	No
SECTION B: #18B HEARING AIDS - BASE 1	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
SECTION B: #18B HEARING AIDS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	600.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every three years
SECTION B: #18B HEARING AIDS - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18B HEARING AIDS - BASE 4	

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Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	Yes
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	: Value-Based Design Flexibilities by Condition or Socioeconomic Status : Medicare Advantage Rewards and Incentives Programs
Value-Based Insurance Design Attestation	: I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	Yes
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s)	20.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	AVAILABLE TO REEDEEM INSTANTLY OR ACCUMULATE FOR FUTURE REDEMPTION. ONLY AVAILABLE FOR ENROLLEES IN RI COMPONENT.

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Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	1549

SECTION B: #19 VBID PART C REWARDS AND INCENTIVES #1

How many packages of Part C Rewards and Incentives are you offering?	1
Type of Part C Reward or Incentive:	: Gift Card : Item : Other
Part C Reward or Incentive Notes:	LIMITED PURPOSE CARD. USAGE WILL BE RESTRICTED TO CERTAIN CATEGORIES IN SPECIFIC MERCHANTS/RETAILERS. PERMISSIBLE PURCHASES: PREPARED FOOD, FOOD AND GROCERIES OR GASOLINE
Part C Reward or Incentive amount(s):	130.00
Frequency of Reward or Incentive Eligibility:	Other, Describe
Other Description:	PARTICIPATING ENROLLEES CAN REDEEM REWARDS INSTANTLY, OR CAN OPT TO ACCUMULATE EARNED FUNDS FOR FUTURE REDEMPTION.
Eligibility Criteria:	BENEFICIARIES WITH A QUALIFYING CHRONIC DIAGNOSIS OF DIABETES AND/OR CONGESTIVE HEART THAT MEET THE FOLLOWING INCLUSION CRITERIA FOR THE INTEGRATED CARE MANAGEMENT PRACTICE UNITS (ICMPUS), AND ARE ACTIVE PARTICIPANTS OF THE STATED PROGRAM WILL BE ELIGIBLE TO RECEIVE THE PART C REWARDS AND INCENTIVES: APPLICABLE TO CONGESTIVE HEART DIAGNOSIS, TWO OR MORE INPATIENT ADMISSIONS IN THE PAST YEAR AND/OR READMISSION WITHIN THIRTY DAYS, AND/OR TWO ER VISITS/MONTH IN TWO CONSECUTIVE MONTHS, AND/OR POLYPHARMACY (MORE THAN EIGHT MEDICATIONS). CONCERNING THE DIABETES DIAGNOSIS, ONLY THE CRITERION OF POLYPHARMACY WILL APPLY.

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	ENROLLEES THAT COMPLY WITH THE STATED INCLUSION PARAMETERS, BUT ARE ENDURING THE FOLLOWING HEALTH CARE STAGES WILL BE EXCLUDED: ESRD (RECEIVING DIALYSIS), ALZHEIMER'S (SEVERE OR LATE STAGE), ACTIVE CANCER (RECEIVING CHEMOTHERAPY/RADIOTHERAPY), INFECTIOUS OR PARASITIC DISEASE, HIV/ACTIVE, HEPATITIS, BEDRIDDEN, SERIOUS MENTAL DISORDERS, AND ORGAN TRANSPLANT RECIPIENTS.
Maximum Annual Part C Rewards and Incentives Available:	150.00

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes
How many packages does your 19a Reduction in Cost Sharing VBID/MA Uniformity Flexibility/SSBCI benefit contain? (1-15)	1

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID, MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	22313
Expected Number of Enrollees to be engaged and receive Model benefits:	22313

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for reduction of cost sharing for this package?	No
Does the plan reduce cost sharing to $0 for all covered benefits, up to a maximum aggregate amount?	No
Select the benefits that apply to reduced cost sharing:	: Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced cost sharing:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 2

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(OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 3 (REDUCED COINSURANCE): PACKAGE #1

Do you offer reduced Coinsurance?	Yes
Select the types of benefits that apply to the coinsurance cost sharing:	: Medicare-covered benefits
Select the Medicare-covered benefits that will receive reduced coinsurance:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 5 (REDUCED COINSURANCE): PACKAGE #1

Indicate Minimum Coinsurance Percentage for Durable Medical Equipment (DME)	0%
Indicate Maximum Coinsurance Percentage for Durable Medical Equipment (DME)	0%
Indicate Minimum Coinsurance Percentage for Prosthetic Devices	0%
Indicate Maximum Coinsurance Percentage for Prosthetic Devices	0%
Indicate Minimum Coinsurance Percentage for Medical Supplies	0%
Indicate Maximum Coinsurance Percentage for Medical Supplies	0%

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 8 (REDUCED DEDUCTIBLE): PACKAGE #1

Do you offer a reduced deductible amount?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 10 (REDUCED COPAYMENT): PACKAGE #1

Do you offer reduced Copayment?	No

SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - BASE 18 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a maximum aggregate amount of reduced cost sharing?	Yes
Specify the maximum aggregate amount of reduced cost sharing:	200.00

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SECTION B: #19A REDUCED COST SHARING FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B.

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #1

Targeting Methodology - Please choose one or both:	: Socioeconomic Status
Select LIS reduction level:	: Dual-Eligible Status (for territories)
Expected Number of Enrollees to be Targeted:	22313
Expected Number of Enrollees to be engaged and receive Model benefits:	22313

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13h: Over-the-Counter (OTC) Items : 13i: Non-Primarily Health Related Benefits for the Chronically Ill : 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other) : 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #1

Is there a package level maximum coverage amount?	Yes
Specify the maximum benefit amount:	200.00
Select the package level maximum coverage periodicity:	Every month
Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	: 13b: Over-the-Counter (OTC) Items : 13i1: Food and Produce : 13i2: Meals (beyond limited basis) : 13i3: Pest Control : 13i6: Social Needs Benefit : 13i10: General Supports for Living : 13i-O1: Other 1 Non-Primarily Health Related

	Benefit : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD WILL BE AVAILABLE TO BE USED FOR ALL PRIMARILY AND NON-PRIMARILY HEALTH RELATED SERVICES INCLUDED WITHIN VBID PACKAGES IN CATEGORIES 19A AND 19B, SUCH AS: - FOOD & GROCERIES - MEALS BEYOND LIMITED BASIS (PREPARED FOOD) - GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS) - PEST CONTROL (CLEANING PRODUCTS) - SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES) - ADDITIONAL OTC ITEMS - ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY) - HOME AND BATHROOM SAFETY DEVICES - PET CARE - PERSONAL CARE ITEMS - ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES - FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY) ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS WILL ALSO BE COVERED. THE MAXIMUM BENEFIT COVERAGE ALLOWANCE WILL NOT APPLY TO THESE SERVICES.

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SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 1: PACKAGE #1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan	Yes

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Benefit Coverage amount?	
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: VBID/UF/SSBCI 19B #13B OTC ITEMS - BASE 3: PACKAGE #1

Notes:

THE FOLLOWING HEALTH & NON HEALTH RELATED CATEGORIES ARE COVERED:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING,

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	BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN) 11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP) 12) PERSONAL HYGIENE PRODUCTS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Food and Produce : Meals (beyond limited basis) : Pest Control : Social Needs Benefit : General Supports for Living

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #1

Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
Select type of benefit for Food and Produce:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Food and Produce?	No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes:	MONTHLY ALLOWANCE.

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 1: PACKAGE #1

Does the plan provide Meals (beyond limited basis) as a supplemental benefit under Part C?	Yes
Select type of benefit for Meals (beyond limited basis):	Mandatory
Is the meal benefit unlimited?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage	200.00

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amount:	
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for the Meals (beyond limited basis)?	No

SECTION B: VBID/UF/SSBCI 19B #13I MEALS (BEYOND LIMITED BASIS) - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PREPARED FOOD.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
Select type of benefit for Pest Control:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Pest Control?	No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ITEMS SUCH AS: CLEANING PRODUCTS.

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 1: PACKAGE #1

Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
Select type of benefit for Social Needs Benefit:	Mandatory
Is there a service-specific Maximum Plan	Yes

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Benefit Coverage amount?	
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Social Needs Benefit?	No

SECTION B: VBID/UF/SSBCI 19B #13I SOCIAL NEEDS BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING ENTERTAINMENT (CONCERTS / THEATER / MOVIES), GARDENING ITEMS, PERSONAL GROOMING SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #1

Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
Select type of benefit for General Supports for Living:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for General Supports for Living?	No

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SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING GASOLINE, UTILITIES, HOME

	APPLIANCES, TOWELS / LINENS AND CLOTHING, HARDWARE ITEMS.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #1

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2 : Other 3

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PET CARE
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 1 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PET FOOD AND SUPPLIES, SUCH AS: LEASH, COLLARS, VET VISITS, GROOMING ITEMS AND SERVICES.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	PERSONAL CARE ITEMS
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	200.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED

BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	UNDER THIS CATEGORY WE WILL BE COVERING PERSONAL CARE ITEMS SUCH AS: HAIR GROWTH AND ANTI-AGE / SPOT CREAMS.

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #1

Enter name of Service:	ROADSIDE ASSISTANCE, IN-HOME MINOR REPAIRS AND OTHER
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	300.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 3 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 3 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #1

Notes:	MEMBER WILL BE ELIGIBLE FOR UP TO 12 INDIVIDUAL EVENTS A YEAR FOR: 1. ROADSIDE ASSISTANCE SERVICES* (UP TO ONE WINDSHIELD REPLACEMENT AND BATTERY REPLACEMENT PER YEAR) 2. IN-HOME MINOR REPAIRS* 3. PEST CONTROL (1 PER QTR.) 4. ANTI-FALL PREVENTIVE MEASURES VISIT (INCLUDES AN EVALUATION OF THE HOME AND INSTALLATION OF LED

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LIGHTING, TRACTION / ANTI-SLIP TAPE. GRIP AND SAFETY BARS COULD ALSO BE INSTALLED IF THE MEMBER PROVIDES THEM. (1 VISIT PER YR.)
5. TECHNOLOGY CONNECTIVITY SERVICES (1 IN-PERSON VISIT AND UNLIMITED REMOTE SUPPORT PER YR.)

*MAXIMUM AMOUNT OF $300 PER SERVICE FOR ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS.

IN ADDITION, MEMBER CAN USE THE $200 MONTHLY ALLOWANCE FOR ADDITIONAL ROADSIDE ASSITANCE, IN-HOME MINOR REPAIRS AND OTHER SERVICES.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c4: Fitness Benefit* : 14c8: Home and Bathroom Safety Devices and Modifications* : 14c17: Alternative Therapies*
Select type of benefit for Fitness Benefit:	Mandatory
Indicate type of Fitness Benefit offered (Select all that apply):	: Physical Fitness : Memory Fitness
Select type of benefit for Home and Bathroom Safety Devices and Modifications:	Mandatory

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	Yes

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	Yes
Select which Other Defined Supplemental Benefits have a Maximum Plan Benefit Coverage amount (Select all that apply):	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
Indicate Maximum Plan Benefit Coverage amount for Fitness Benefit:	200.00

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Select Maximum Plan Benefit Coverage periodicity for Fitness Benefit:	Monthly

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 5: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Home and Bathroom Safety Devices and Modifications:	200.00
Select Maximum Plan Benefit Coverage periodicity for Home and Bathroom Safety Devices and Modifications:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Indicate Maximum Plan Benefit Coverage amount for Alternative Therapies:	200.00
Select Maximum Plan Benefit Coverage periodicity for Alternative Therapies:	Other, Describe

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Fitness Benefit Notes:*	ITEMS SUCH AS THE FOLLOWING WILL BE COVERED: 1) PHYSICAL EXERCISE PEDALS 2) STRETCH STRAPS 3) PUZZLES FOR MEMORY FITNESS ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

Home and Bathroom Safety Devices and Modifications Notes:*	MONTHLY ALLOWANCE. ITEMS SUCH AS THE FOLLOWING WILL

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	BE COVERED: 1) MEDICAL BATHMAT 2) RAISED TOILET SEAT 3) HANDHELD SHOWER HEAD 4) REACHER 5) NIGHTLIGHT ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

Alternative Therapies Notes:*	MONTHLY ALLOWANCE. UNDER THIS CATEGORY WE WILL COVER HOMEOPATHIC / NATURAL MEDICINE ITEMS. ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - TARGET POPULATION: VBID: PACKAGE #2

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Diabetes
Expected Number of Enrollees to be Targeted:	1549
Expected Number of Enrollees to be engaged and receive Model benefits:	320

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13d: Other 1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (MAXIMUM AGGREGATE AMOUNT): PACKAGE #2

Is there a package level maximum coverage amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

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Notes:	NEW AND INNOVATIVE TECHNOLOGIES

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 1: PACKAGE #2

Enter name of Service (Optional):	NEW AND INNOVATIVE TECHNOLOGIES
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	Yes

SECTION B: VBID/UF/SSBCI 19B #13D OTHER 1 - BASE 3: PACKAGE #2

Notes:	THE INTENTION IS TO UTILIZE A PROFESSIONAL CONTINUOUS GLUCOSE MONITORING (CGM) DEVICE INDICATED FOR DETECTING TRENDS AND TRACKING PATTERNS AND GLUCOSE LEVEL EXCURSIONS ABOVE OR BELOW THE DESIRED RANGE, FACILITATING THERAPY ADJUSTMENTS IN PERSONS (AGE 18 AND OLDER) WITH DIABETES. THE SYSTEM IS INTENDED FOR USE BY HEALTH CARE PROFESSIONALS.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

SECTION B: #19C VBID HOSPICE- BASE 2

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Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for prescription drugs and biologics:	5%
Indicate the maximum per drug amount	5
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	Yes
Indicate the Minimum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the Maximum Coinsurance percentage for Medicare covered Benefits for a respite care day:	5%
Indicate the maximum per day amount	5

SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits?	No

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Lower, Intermediate or Mandatory Level?	Lower
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3250.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits : In-Network Non-Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Non-Medicare-covered plan services?	Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	Yes
How many groups of Reductions in Cost Sharing are you offering?	1

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 1

Select the benefits that apply to the Reductions	: Medicare-covered benefits

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in Cost Sharing benefit:	
Select which Medicare-Covered Services your Reductions in Cost Sharing apply to:	: 11a: Durable Medical Equipment (DME) : 11b1: Prosthetic Devices : 11b2: Medical Supplies

SECTION D: REDUCTIONS IN COST SHARING #1 - BASE 2

Indicate Max Plan Benefit amount:	200.00
Select Reductions in Cost Sharing periodicity:	Every month
Can the reduction in cost sharing be applied to a deductible?	No
What is your Reductions in Cost Sharing mode of delivery?	: Debit Card
Notes:	MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO REDUCE COST SHARING FOR THE LISTED SERVICES IN THE COMBINED PACKAGE. MEMBER IS RESPONSIBLE FOR COSTS THAT EXCEED THE ALLOWANCE.

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	2

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 13b: Over-the-Counter (OTC) Items : 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies
What is your combined supplemental benefits mode of delivery?	: Other
Other Description:	MEMBER WILL BE ABLE TO USE THE COMBINED ALLOWANCE TO PURCHASE ITEMS FROM A CATALOG.
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	60.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every three months
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: COMBINED BENEFITS #2

Select which non-Medicare covered benefits are	: 13b: Over-the-Counter (OTC) Items

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included in your Combined Supplemental Benefit package:	: 14c4: Fitness Benefit : 14c8: Home and Bathroom Safety Devices and Modifications : 14c17: Alternative Therapies : 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	: Debit Card
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	200.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every month
Do you offer Combined Supplemental Benefits with a shared visit limit?	No

SECTION D: NOTES

Notes:

COMBINED BENEFITS #1:
THE FOLLOWING CATEGORIES ARE COVERED FOR OTC:
1) MINERALS AND VITAMINS
2) FIRST AID SUPPLIES
3) MEDICINES, OINTMENTS AND SPRAYS WITH ACTIVE MEDICAL INGREDIENTS THAT ALLEVIATE SYMPTOMS
4) MOUTH CARE
5) INCONTINENCE SUPPLIES (ADULT DIAPERS & UNDER PADS)
6) IN HOME TESTING AND MONITORING SPECIFICALLY MONITOR BLOOD PRESSURE (FOR MEMBERS WHO MEET MEDICAL CRITERIA FOR ON-GOING MONITORING OF BLOOD PRESSURE, THE PLAN WILL PROVIDE ONE (1) BLOOD PRESSURE MONITOR UNIT EVERY 5 YEARS. THIS BENEFIT MAY REQUIRE MEDICAL EVALUATION AND/OR PREAUTHORIZATION.
7) FIBER SUPPLEMENTS
8) TOPICAL SUNSCREEN
9) SUPPORTING ITEMS FOR COMFORT
10) SKIN MOISTURIZERS (INCLUDING, BUT NOT LIMITED TO FACE, BODY, AND FOOT LOTIONS USED FOR DRY SKIN)
11) SOAP (DOCTOR RECOMMENDED ANTIBACTERIAL/ANTIMICROBIAL SOAP)

THE FOLLOWING ITEMS ARE COVERED

FOR HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS:
1) MEDICAL BATHMAT
2) RAISED TOILET SEAT
3) HANDHELD SHOWER HEAD
4) REACHER
5) NIGHTLIGHT

THE FOLLOWING ITEMS WILL BE COVERED FOR ALTERNATIVE THERAPIES:
1) HOMEOPATHIC AND NATURAL MEDICINE ITEMS

THE FOLLOWING ITEMS WILL BE COVERED FOR FITNESS BENEFIT:
1) PHYSICAL EXERCISE PEDALS
2) STRETCH STRAPS
3) PUZZLES FOR MEMORY FITNESS

THIS IS A COMBINED BENEFIT WITH A SINGLE, SHARED MAXIMUM BENEFIT AMOUNT FOR OTC, ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY), HOME AND BATHROOM SAFETY DEVICES AND MODIFICATIONS AND FITNESS BENEFIT.

ITEM QUANTITY LIMITS IN EACH CATEGORY MAY APPLY.

Notes:

COMBINED BENEFITS #2:
MONTHLY ALLOWANCE IN THE FORM OF A DEBIT CARD. THE DEBIT CARD ALLOWS THE MEMBER TO ACCESS ADDITIONAL PRIMARILY HEALTH AND NON-PRIMARILY HEALTH RELATED SUPPLEMENTAL BENEFITS, SUCH AS.
- FOOD & GROCERIES
- MEALS BEYOND LIMITED BASIS (PREPARED FOOD)
- GENERAL SUPPORTS FOR LIVING (GASOLINE / UTILITIES / HOME APPLIANCES / TOWELS/LINENS AND CLOTHING / HARDWARE ITEMS)
- PEST CONTROL (CLEANING PRODUCTS)
- SOCIAL NEEDS BENEFIT (ENTERTAINMENT (CONCERTS / THEATER / MOVIES) / GARDENING ITEMS / GROOMING SERVICES)
- ADDITIONAL OTC ITEMS

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- ALTERNATIVE THERAPIES (HOMEOPATHIC / NATURAL MEDICINE ITEMS ONLY)
- HOME AND BATHROOM SAFETY DEVICES
- PET CARE
- PERSONAL CARE ITEMS
- ADDITIONAL ROADSIDE ASSISTANCE AND IN-HOME MINOR REPAIRS AND OTHER SERVICES
- FITNESS BENEFIT (PHYSICAL EXERCISE AND MEMORY FITNESS ITEMS ONLY)

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard
Describe the components of your pharmacy network (select all that apply):	: Standard Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Do you pay for over-the-counter medications (OTCs) under the utilization management program?	No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Location/supply amount(s) that apply:	: Standard Retail Cost Sharing - 1 month Supply : Standard Retail Cost Sharing - 3 month Supply
Enter number of days for Standard Retail Cost Sharing 1-month supply:	30
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply:	: Out-of-Network Pharmacy - one month supply
Enter number of days for Out-of-Network Pharmacy 1-month supply:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No

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Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	No

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No