Appendix C-1





PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 024, SEGMENT 0

Module: PBP Requested By: m660

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 06/03/2019 04:21:54 PM SA Western Standard

Time

MA BPT Timestamp: 06/03/2019 08:13:26 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2019 06:04:37 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/03/2019 08:59:46 PM SA Western Standard

Time

Upload Status: 06/03/2019 #02479

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 Completed Section B5 Status Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Completed Section B9 Status

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



M

ahantihladi.

Organization Legal Name:

Organization Marketing Name:

Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

TRIPLE S ADVANTAGE, INC.

Triple S Advantage

www.sssadvantage.com

Platino Plus (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



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

Service Area(s):

Service Area(s):

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Service Area(s):

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ervice Area(s):

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

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



	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	024
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member months for this plan:	324000
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.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number	(888)620-1919

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

Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number

(877)207-8777

(877)207-8777

(877)207-8777

(888)620-1919

(888)620-1919

(877)207-8777

for Prospective Part D Medicare Beneficiaries:

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
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-A	CUTE - BASE 1



Select enhanced benefits:

C?

: Additional Days

Select type of benefit for Additional Days:

Mandatory

Is this benefit unlimited for Additional Days?

Does the plan provide Inpatient Hospital-Acute

Services as a supplemental benefit under Part

Yes

Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

Is there an enrollee Coinsurance?

No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing

No

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

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

Νo

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

No

C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

No

Dut-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance? No

SECTION B: #2 SNF - BASE 6

No Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

Yes Is authorization required?

No Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

Services in the USA may also be available Notes:

> through reimbursement in accordance with Medicare rates and the location where services

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3



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Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

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

amount for w

Yes

Coverage?

Is the service-specific Maximum Plan Benefit

No

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage

amount:

75.00

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?

No

Is there an enrollee Deductible?

No

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

Notes:

Worldwide services are covered through

reimbursement in accordance with Triplest

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

111

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2





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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes No

No

Is a referral required for Home Health Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

No Is there an enrollee Copayment? SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

: Routine Care Select enhanced benefit:

Mandatory Select type of benefit for Routine Care:

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

Indicate number of visits for Routine Care:

Every year Select Routine Care periodicity:

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

No Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required? No Is a referral required for Occupational Therapy

Services?

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



Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes
Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee N

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Is a referral required for Mental Health No Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

No

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: 4

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required?

No

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? No Is a referral required for Psychiatric Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit No

for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

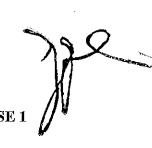
Out-of-Pocket Cost?

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

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Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Νo

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered

Yes

Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

Juipatient Hospital Services:

No

Is a referral required for Medicare-covered Observation Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 3

Notes:

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #9B ASC SERVICES - BASE 2





Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?

SECTION B: #9B ASC SERVICES - BASE 3

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

No
Is a referral required for Outpatient Substance

No

Abuse?

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

Does the plan provide Outpatient Blood Yes Services as a supplemental benefit under Part

C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3



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Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Select enhanced benefit:

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Yes

Yes

No

24

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Every year

One-way

: Taxi

: Van

No

Select Type of Transportation for Plan Approved Health-related Location:

Select Mode of Transportation for Plan
Approved Health-related Location:

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

Notes: Other method of transportation is available in an

0%

automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2



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Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required?

Notes:

Yes

Yes

0% coinsurance for preferred brands and

manufacturers.

10% coinsurance for non preferred brands and

manufacturers.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

No

Yes : Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

0%

10% 0%

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?

Notes:

Yes

10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0%

coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for medical supplies preferred brands and manufacturers.10% coinsurance for medical supplies non preferred brands and

manufacturers.

0% coinsurance for Cardiovascular Devices.

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?

Is there an enrollee Deductible? No

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

Is there an enrollee Copayment?

No

Nο



Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes	
Is authorization required?	No	
SECTION B: #12 DIALYSIS SERVICES - BAS	E 1	
Is there a service-specific Maximum Enrollee	No	
Out-of-Pocket Cost?	110	
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?	No	
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:	12	
Indicate Number of Treatments 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	
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes	





Is there an enrollee Coinsurance? Νo Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Acupuncture? No **SECTION B: #13A ACUPUNCTURE - BASE 3**

SECTION B: #13A ACUPUNCTURE - BASE 2

Services are subject to the combined maximum Notes: limit with Alternative therapy benefit.



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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

Yes

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Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

75.00

Every three months

No

No

Yes

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

No

No

No

No



Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor.

The Blood Pressure Monitor is covered up to one (1) every 5 years.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive Services Attestation

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

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No

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

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

Remote Access Technologies (Nursing Hotline)

Notes:

Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should.

make a doctor's appointment, visit an emergency room, or they will offer you self-care

instructions to help alleviate your

symptoms safely, in the comfort of your home.

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

Counseling Services Notes:

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

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Alternative Therapies Notes:*

Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include:

- Chinese Medicine
- · Pranic Healing
- Music Therapy
- Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues)
- Naturopathic Medicine
- Traditional Chinese Medicine
- Reflexology

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

No

Is authorization required? No
Is a referral required for Kidney Disease No

Education Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

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

Glaucoma Screening?

Is authorization required for Medicare-covered No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?
Is authorization required for Medicare-covered

Is authorization required for Medicare-covered Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is authorization required for Other Medicare- No

covered Preventive Services?

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

No

No

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Yes

Does the plan offer step therapy?

Does the benefit step from (select all that

apply):

Yes

Part B to Part B?

Part B to Part D?

apply): : Part B to Part D? : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

Yes

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

Yes

as a supplemental benefit under Part C?

Select enhanced benefits:

: Oral Exams

: Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams? No, indicate number

Indicate number of visits for Oral Exams: 1

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory
Is this benefit unlimited for Fluoride Treatment? No, indicate number

Indicate number of visits for Fluoride 1

Indicate number of visits for Fluoride Treatment:

1

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

Is this benefit unlimited for Dental X-Rays? No, indicate number

Indicate number of visits for Dental X-Rays:

1



Select the Dental X-Rays periodicity:

Other, Describe

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Nο

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

No

Is a referral required for Preventive Dental

No

Services?

Up to (1) Panoramic image or Intraoral Notes:

complete series including bitewings, every three years. Once the member has used the Panoramic

images or Intraoral complete series, the

radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

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:

: Non-routine Services

: Diagnostic Services : Restorative Services

: Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes



Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

2500.00

Every year

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No



Restorative: Amalgams and Composites Resin restorations-every 24 month, Core build up and Pin retention-1 per tooth every 5 years, Protective restorations-1 treatment per tooth per life, Prefabricated stainless steel crown for primary teeth (baby teeth)-1 per tooth per life / Periodontics: Root Planning and curettage-1 per quadrant every two years, Full mouth debriment-1 every twelve month, Periodontal maintenance- 1 every six-month concluded periodontal therapy since the last prophylaxis / Endodontics-1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent. Root canal therapy for anterior teeth and bicuspids, Retreatments for anterior teeth and bicuspids 1 per tooth per life /

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Prosthodontic-The placement of Removable Prosthesis will be covered 1 per arch every 5 years: Adjustments-after the initial insertion all adjustments are included in the prosthesis fee up to 6 month, Repairs-3 repair codes in a period of 5 years per prosthesis, Rebase-1 per arch every 5 years, Relines-1 per arch every 5 year, Flexible base material not covered (valplast) / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue-1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

SECTION B: #17A EYE EXAMS - BASE 1

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

Select type of benefit for Routine Eye Exams: Is this benefit unlimited for Routine Eye Exams?

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

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

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

Every year

No

No

No

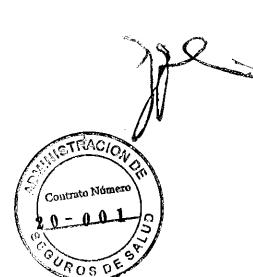
No

No

No

Νo

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.



SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a

supplemental benefit under Part C?

Select enhanced benefits:

Yes

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses Yes

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Yes Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames?

Select type of benefit for Upgrades: Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Yes Is there a service-specific Maximum Plan

Benefit Coverage amount?

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

type:

Do you offer a Combined Max Plan Benefit Yes

Coverage Amount for all Eyewear?

850.00 Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

No Is authorization required?

Is a referral required for Eyewear? Νo

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a Yes

Supplemental benefit under Part C?

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: Routine Hearing Exams Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Mandatory Select type of benefit for Routine Hearing Exams: No, indicate number Is this benefit unlimited for Routine Hearing Exams? 1 Indicate number for Routine Hearing Exams: Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: No, indicate number Is this benefit unlimited for Fitting/Evaluation for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Every year Select Fitting/Evaluation for Hearing Aid periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** No Is there a service-specific Maximum Plan Benefit Coverage amount? Is there an enrollee Deductible? No No Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Coinsurance?

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

Is a referral required for Hearing Exams?

SECTION B: #18B HEARING AIDS - BASE 1

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

: Hearing Aids (all types) Select enhanced benefits:

No

Mandatory Select type of benefit for Hearing Aids (all

Yes Is this benefit unlimited for Hearing Aids (all

types)? **SECTION B: #18B HEARING AIDS - BASE 2**

Amount apply per ear or for both ears

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined

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

Indicate Maximum Plan Benefit Coverage 2000.00

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nosp



types):

ambunt

Every year Indicate Maximum Plan Benefit Coverage periodicity: SECTION B: #18B HEARING AIDS - BASE 3 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? **SECTION B: #18B HEARING AIDS - BASE 4** Is there an enrollee Copayment? No No Is there an enrollee Deductible? SECTION B: #18B HEARING AIDS - BASE 5 No Is authorization required? No Is a referral required for Hearing Aids? SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI Does your plan include MA Uniformity No Flexibility with reductions in cost or additional benefits? Do you offer Special Supplemental Benefits for Νo the Chronically Ill? 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) Yes

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your network

(select all that apply):

Yes

No

Yes

Voluntary

3400.00

Actuarially Equivalent Standard

: Standard/Preferred Retail Cost-Sharing

: In-Network Medicare-covered benefits

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

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

Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

OTC Medication Attestation statement

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

What is your Formulary Exception Tier?

Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan: Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Yes

6

4

No

Yes

No

Yes

Yes

No

Yes

Yes



SECTION RX: TIER #1 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Preferred Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing one month supply

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

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

Tier:

Select all Standard Mail Order Cost-Sharing

Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

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Tier:

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Yes

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

No

supply for the first fill?

SECTION RX: TIER #1 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order Cost-Sharing in your three month supply:

90

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$38.00



Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$14.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing three month supply:

SECTION RX: TIER #1 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$28.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$14.00

Care Pharmacy one month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment

\$0.63

Daily Preferred Retail Copayment

\$0.47

Daily Copayment for Long Term Care

\$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier:

: Standard Mail Order Cost-Sharing - three

month supply

Tier (Optional):

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

90





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Nos o

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

\$20.00

Pharmacy one month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Indicate Copayment amount for Standard Retail

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #2 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail \$30.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$15.00

Care Pharmacy one month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.67

Daily Preferred Retail Copayment \$0.50

Daily Copayment for Long Term Care \$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply): : Brand
Tier Includes: Part D Drugs Only

Indicate the type of cost sharing structure: Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost- : Standard Retail/Preferred Retail Cost-Sharing -

Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

one month supply

: Standard Retail/Preferred Retail Cost-Sharing three month supply

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

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

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

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Tier:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

SECTION RX: TIER #3 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$47.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail Cost-Sharing three month supply:

\$94.00

Indicate Copayment amount for Preferred Retail

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing one month supply:

\$84.00

Cost-Sharing three month supply:

SECTION RX: TIER #3 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$84.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

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Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy one month supply:

\$42.00 Indicate Copayment Amount for Long Term

Care Pharmacy one month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$1.57 Daily Standard Retail Copayment \$1.40 Daily Preferred Retail Copayment \$1.35 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Brand

Part D Drugs Only Tier Includes:

Copayment Indicate the type of cost sharing structure: SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month supply for the first fill?

Yes

90

Yes

90

SECTION RX: TIER #4 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

Cost-Sharing in your three month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL



Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing three month supply:

SECTION RX: TIER #4 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$190.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$95.00

Care Pharmacy one month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-IC

\$3,33 Daily Standard Retail Copayment \$3.17 Daily Preferred Retail Copayment \$3.06 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICI

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

one month supply

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

Select all Out-of-Network Pharmacy

three month supply

Location/supply amount(s) that apply for this

: Out-of-Network Pharmacy - one month supply

Tier:

Select all Standard Mail Order Cost-Sharing

Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

: Standard Retail/Preferred Retail Cost-Sharing -

month supply



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

Tier:

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Yes

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

supply for the first fill?

SECTION RX: TIER #5 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE

ICL

Avg Expected Coins Dollar Amt Standard

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing one month supply:

25%

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing three month supply: Avg Expected Coins Dollar Amt Preferred

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing one month supply: Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing three month supply:

SECTION RX: TIER #5 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail Order Cost-Sharing three month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

25%

Network Pharmacy one month supply:

Indicate Coinsurance percentage for Long Term

Care Pharmacy one month supply:

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SECTION RX: TIER #6 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic : Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

that apply for this Tier:

: Out-of-Network Pharmacy - one month supply

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

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

Yes

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month supply for the first fill?

SECTION RX: TIER #6 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-**ICL**

\$8.00

Indicate Copayment amount for Standard Retail

Cost-Sharing one month supply:



\$16,00 Indicate Copayment amount for Standard Retail

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$3.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$6.00

Cost-Sharing three month supply:

SECTION RX: TIER #6 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$6.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$8.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$3.00

Care Pharmacy one month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.27 Daily Standard Retail Copayment \$0.10 Daily Preferred Retail Copayment

Daily Copayment for Long Term Care

\$0.10

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

Medicare-defined Post Threshold Cost Shares How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

3 Select drug type(s) in this Tier (select all that : Brand

apply): Tier Includes:

Part D Drugs Only





SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):

Tier Includes: Part D Drugs Only

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Specialty Tier

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

6

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only

W.



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 025, SEGMENT 0

Module: PBP Requested By: m660

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 06/03/2019 04:24:18 PM SA Western Standard

Time

MA BPT Timestamp: 06/03/2019 08:14:08 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2019 06:05:06 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/03/2019 08:59:46 PM SA Western Standard

Time

Upload Status: 06/03/2019 #02479

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B6 Status

Section B6 Status

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

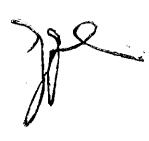
Section B16 Status Completed
Section B17 Status Completed

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





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

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

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Ultra (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR

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	Service Area(s):
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	Service Area(s):
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	Service Area(s):
	Service Area(s):
	Comica Anagla).

Service Area(s):

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

about:blank

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



POSU

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	025
Segment ID:	0 .
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member	162000
months for this plan:	2.7
Does this Plan have a CMS-approved	No
Continuation Area?	Yes
Do you intend to participate in the PLATINO program?	103
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.sssadvantage.com
Formulary Website Address: www.sssadvantage.com
Physician Website Address: www.sssadvantage.com

Customer Service Contact Phone Number for (888)620-1919 Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number (888)620-1919 for Current Medicare Beneficiaries:

Customer Service Contact Phone Number for (877)207-8777

Prospective Medicare Beneficiaries:
Customer Service Contact Local Phone Number (877)207-8777

for Prospective Medicare Beneficiaries:
Customer Service Contact Phone Number for (888)620-1919

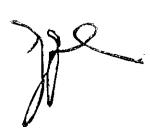
Current Part D Medicare Beneficiaries:
Customer Service Contact Local Phone Number (888)620-1919

for Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for
Prospective Part D Medicare Beneficiaries:

(877)207-8777

SECTION A: SECTION A-4
Customer Service Contact Local Phone Number (877)207-8777





for Prospective Part D Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
SECTION A: SECTION A-5	3.Y-	
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-A	CUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes	
Select enhanced benefits:	: Additional Days	
Select type of benefit for Additional Days:	Mandatory	
Is this benefit unlimited for Additional Days?	Yes	
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	
Commission of the contract of	5 T	

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

No



Is there an enrollee Coinsurance?

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

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?
Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

- . . .

C?

Do you allow less than 3 day inpatient hospital

7. Y ..

stay prior to SNF admission?

No

Is there a service-specific Maximum Enrollee,

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance? No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Nο Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

No

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

Yes Is authorization required?

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

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

Is there an enrollee Copayment?

Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services

were provided.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3



Contrato Námero

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Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

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

75.00

amount:

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

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

Notes:

'Worldwide services are covered through reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? Is authorization required?

Is a referral required for Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

No

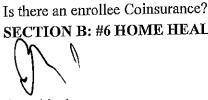
No

Yes

No

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2





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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?

Yes

Is a referral required for Home Health Services?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

SECTION B: #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:

Select Routine Care periodicity:

Every year No

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

Is there a service-specific Maximum Enrollee No

Is a referral required for Chiropractic Services?

Out-of-Pocket Cost?

Yes

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

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

Yes Is authorization required?

Is a referral required for Occupational Therapy

No

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







Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required? Is a referral required for Physician Specialist Yes

Services?

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

No Is authorization required? No Is a referral required for Mental Health

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 4

Every year Select the Routine Foot Care periodicity: No

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No



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

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

Is authorization required?

No

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

No Is authorization required?

Is a referral required for Psychiatric Services? No

SECTION B: #71 PT AND SP SERVICES - BASE 1

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

Is there an enrollee Coinsurance? No

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

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

Yes Is authorization required? Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Νo for Part B services?

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

No Is authorization required? No

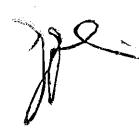
Is a referral required for Opioid Treatment Services?

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

Is there a service-specific Maximum Enrollee Νo

Out-of-Pocket Cost?

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





Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered

Yes

Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 3

Notes:

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #9B ASC SERVICES - BASE 2





Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?

SECTION B: #9B ASC SERVICES - BASE 3

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

No
Is a referral required for Outpatient Substance

No

Abuse?

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

Does the plan provide Outpatient Blood Yes Services as a supplemental benefit under Part

C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

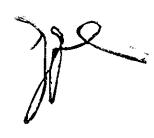
SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes







Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location

Select enhanced benefit: Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

No 24

Yes

One-way

Select Plan Approved Health-related Location

Trips periodicity:

Every year

Select Type of Transportation for Plan

Approved Health-related Location:

Select Mode of Transportation for Plan Approved Health-related Location:

: Taxi : Van

No

No

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

. Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

No Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

Other method of transportation is available in a Notes: automobile through a contracted provider.

10%

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes 0%

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Yes



Durable Medical Equipment (DME)?

Is authorization required?

Yes

Notes:

0% coinsurance for preferred brands and

manufacturers.

10% coinsurance for non preferred brands and

manufacturers.

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:

0%

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

10%

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

0%

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

Notes:

10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and non-surgically implanted prosthetic devices.

0% coinsurance for medical supplies preferred

brands and manufacturers.

10% coinsurance for medical supplies non preferred brands and manufacturers.

0% coinsurance for Cardiovascular Devices.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

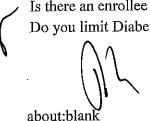
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?

No

Do you limit Diabetic Supplies and Services to

Yes





those from specified manufacturers?	
Is authorization required?	No
SECTION B: #12 DIALYSIS SERVICES - BASE	1
	No
Is there an emotice comstraines.	No
is there an enfonce beddedole:	No
is there an emonee copayment.	No
SECTION B: #12 DIALYSIS SERVICES - BASE	
Is authorization required:	No
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:	\sim
Indicate Number of Treatments 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
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes Shinistracion
SECTION B: #13A ACUPUNCTURE - BASE 2	Contrato Número
Is there an enrollee Coinsurance?	No (0 1)
Is there an enrollee Deductible?	No No No
Is there an enrollee Copayment?	No No DE SAL
Is authorization required?	* · ·
Is a referral required for Acupuncture?	No
SECTION B: #13A ACUPUNCTURE - BASE 3	(
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.
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:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

75.00

Every three months

No

No

Yes

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

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

OTC or formulary drugs.

No No No

No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adul

Diapers/Pads and Blood Pressure Monitor.

The Blood Pressure Monitor is one (1) every 5 years.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive Services Attestation

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

about:blank

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zero dollar cost sharing.

Is authorization required?

Is a referral required?

No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: Health Education

: Nutritional/Dietary Benefit

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

Hotline)*

: Counseling Services : Alternative Therapies*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary

Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Mandatory

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Select type of benefit for Counseling Services:

Mandatory

Is this benefit unlimited for Counseling

Yes

Services?

Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or

Yes

Acupuncture benefit, or both?

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

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Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

Counseling Services No.

This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

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

Remote Access Technologies (Nursing Hotline)

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Notes:

Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

Alternative Therapies Notes:*

Services are subject to the combined maximum limit with Acupuncture benefits. Alternative

therapies include:

Chinese Medicine

Pranic Healing

Music Therapy

· Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues)

Naturopathic Medicine

• Traditional Chinese Medicine

Reflexology

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

Νo

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

Nο

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

Is there an enrollee Copayment?

No

No

Is authorization required for Medicare-covered Glaucoma Screening?

Is authorization required for Medicare-covered

Νo

Diabetes Self-Management Training?

No

Barium Enemas?

Is authorization required for Medicare-covered

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

Is authorization required for Medicare-covered

No

EKG following Welcome Visit?

Is authorization required for Other Medicare-No

covered Preventive Services?

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

about:blank

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Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

No Is there an enrollee Copayment? No Is there an enrollee Deductible? Yes Is Authorization Required? Yes

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

: Part B to Part D? apply): : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Oral Exams

: Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

No, indicate number

Select type of benefit for Oral Exams: Mandatory

No, indicate number Is this benefit unlimited for Oral Exams?

Indicate number of visits for Oral Exams:

Every six months Select the Oral Exams periodicity:

Mandatory Select type of benefit for Prophylaxis

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Select type of benefit for Fluoride Treatment:

Is this benefit unlimited for Fluoride Treatment?

Indicate number of visits for Fluoride

Treatment:

Every six months

No, indicate number

Every six months

Mandatory

Select the Fluoride Treatment periodicity:

SECTION B: #16A PREVENTIVE DENTAL - BASE 2 Select type of benefit for Dental X-Rays:

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits for Dental X-Rays:

Mandatory

No, indicate number

1

1

1



Select the Dental X-Rays periodicity:

Other, Describe

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Νo

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

No

Is a referral required for Preventive Dental

Services?

No

Notes:

Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits:

Yes

: Non-routine Services : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes





Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

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

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

3000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

Services?

No

Notes:

Restorative: Amalgams and Composites Resin restorations-every 24 month, Core build up and Pin retention-1 per tooth every 5 years, Protective restorations-1 treatment per tooth per life, Prefabricated stainless steel crown for primary teeth (baby teeth)-1 per tooth per life / Periodontics: Root Planning and curettage-1 per quadrant every two years, Full mouth debriment-1 every twelve month, Periodontal maintenance- 1 every six-month concluded periodontal therapy since the last prophylaxis / Endodontics-1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent. Root canal therapy for anterior teeth and bicuspids, Retreatments for anterior teeth and bicuspids 1 per tooth per life /

Contrato Número

Prosthodontic-The placement of Removable Prosthesis will be covered 1 per arch every 5 years: Adjustments-after the initial insertion all adjustments are included in the prosthesis fee up to 6 month, Repairs-3 repair codes in a period of 5 years per prosthesis, Rebase-1 per arch every 5 years, Relines-1 per arch every 5 year, Flexible base material not covered (valplast) / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue-1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

SECTION B: #17A EYE EXAMS - BASE 1

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

Select type of benefit for Routine Eye Exams: Is this benefit unlimited for Routine Eye Exams?

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

Every year

No

No

No

No

No

No No

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.



Is a referral require Notes:

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)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Select type of benefit for Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

Yes

frames):

Mandatory

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:

Mandatory

Is this benefit unlimited for Eyeglass lenses?

Yes

Select type of benefit for Eyeglass frames:

Mandatory Yes

Is this benefit unlimited for Eyeglass frames?

Mandatory

Select type of benefit for Upgrades:

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

No Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

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

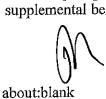
SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

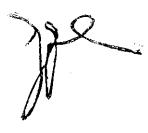
supplemental benefit under Part C?

Yes









amount:

: Routine Hearing Exams Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: No, indicate number Is this benefit unlimited for Routine Hearing Exams? Indicate number for Routine Hearing Exams: 1 Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: No, indicate number Is this benefit unlimited for Fitting/Evaluation for Hearing Aid? 1 Indicate number for Fitting/Evaluation for Hearing Aid: Every year Select Fitting/Evaluation for Hearing Aid periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No Contrato Número Out-of-Pocket Cost? **2**0 No Is there an enrollee Coinsurance? SECTION B: #18A HEARING EXAMS - BASE 3 No Is there an enrollee Copayment? OSDE Is authorization required? No Is a referral required for Hearing Exams? No SECTION B: #18B HEARING AIDS - BASE 1 Does the plan provide Hearing Aids as a Yes supplemental benefit under Part C? : Hearing Aids (all types) Select enhanced benefits: Mandatory Select type of benefit for Hearing Aids (all types): Yes Is this benefit unlimited for Hearing Aids (all types)? **SECTION B: #18B HEARING AIDS - BASE 2** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Does the Maximum Plan Benefit Coverage Both ears combined Amount apply per ear or for both ears combined? Plan-specified amount per period Select the Maximum Plan Benefit Coverage Indicate Maximum Plan Benefit Coverage 2000.00

Indicate Maximum Plan Benefit Coverage Every year periodicity: SECTION B: #18B HEARING AIDS - BASE 3 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #18B HEARING AIDS - BASE 4 No Is there an enrollee Copayment? No Is there an enrollee Deductible? SECTION B: #18B HEARING AIDS - BASE'5 No Is authorization required? No Is a referral required for Hearing Aids? SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI No Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits? Do you offer Special Supplemental Benefits for No the Chronically Ill? SECTION C: V/T - GENERAL - US Do you offer a US Visitor/Travel Program? No SECTION D: PLAN DEDUCTIBLE (IN-NETWORK) Is there an In-Network Plan Deductible? No SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK) Is there an In-Network Maximum Enrollee Out-Yes of-Pocket Cost? Is your In-Network Maximum Enrollee Out-of-Voluntary Pocket (MOOP) Cost at the Voluntary or Mandatory Level? Indicate In-Network Maximum Enrollee Out-of-3400.00 Pocket Cost Amount:



: In-Network Medicare-covered benefits

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE
Is there a Maximum Plan Benefit Coverage

No
Amount?

SECTION RX: MEDICARE RX GENERAL 1

Select the benefits that apply to the In-Network

Does the In-Network Maximum Enrollee Out-

Maximum Enrollee Out-of-Pocket cost:

of-Pocket Cost apply to all In-Network

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Select the type of drug benefit:

Actuarially Equivalent Standard

Describe the components of your network

(select all that apply):

(collect all that apply):

(collect all that apply):

(collect all that apply):

Yes

Yes

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

Yes

No

Yes

Yes

No

Yes

Yes

Yes

Sponsor attests that it will comply with 42 CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

OTC Medication Attestation statement

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6
What is your Formulary Exception Tier? 4
Do you apply a second less expensive cost No sharing level for all generic drugs approved for

formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan: Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

How do you apply you Initial Coverage Lim
about:blank



eached?

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SECTION RX: TIER #1 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Preferred Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

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

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

Tier:

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

supply for the first fill?

SECTION RX: TIER #1 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

31

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

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$38.00



Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing three month supply:

SECTION RX: TIER #1 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$28.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$14.00

Care Pharmacy one month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment

\$0.63

Daily Preferred Retail Copayment

\$0.47

Daily Copayment for Long Term Care

\$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICI

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one

month supply:

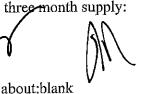
Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your

three month supply:

90

30





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Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

\$20.00

Pharmacy one month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Indicate Copayment amount for Standard Retail

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #2 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$30.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$15.00

Care Pharmacy one month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.67 Daily Standard Retail Copayment \$0.50 Daily Preferred Retail Copayment \$0.48 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL Select all Standard Retail/Preferred Retail Cost-

: Standard Retail/Preferred Retail Cost-Sharing -

Contrato Número

DE

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

SECTION RX: TIER #3 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

Cost-Sharing in your three month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

90

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$47.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$94.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$84.00

Cost-Sharing three month supply:

SECTION RX: TIER #3 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$84.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

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Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$42.00

Care Pharmacy one month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$1.57 Daily Standard Retail Copayment \$1.40 Daily Preferred Retail Copayment \$1.35 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Brand

Part D Drugs Only Tier Includes:

Copayment Indicate the type of cost sharing structure:

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply : Out-of-Network Pharmacy - one month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional): Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your three month supply:

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

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

Yes

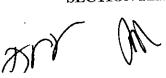
Yes

SECTION RX: TIER #4 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order 90

Cost-Sharing in your three month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL





Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

Pharmacy one month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

30

31

Indicate Copayment amount for Standard Retail \$100.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing three month supply:

SECTION RX: TIER #4 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL \$190.00

Indicate Copayment amount for Standard Mail

Order Cost-Sharing three month supply: SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$100.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

Care Pharmacy one month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICI

\$95.00

Daily Standard Retail Copayment \$3.33 \$3.17 Daily Preferred Retail Copayment \$3.06 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST SHARE STRUCTURE - PRE-IÇI

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Tier Drug type(s) (select all that apply): : Brand

Part D Drugs Only Tier Includes:

Coinsurance Indicate the type of cost sharing structure:

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

: Standard Retail/Preferred Retail Cost-Sharing -Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) one month supply : Standard Retail/Preferred Retail Cost-Sharing -

that apply for this Tier: three month supply

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

Tier: : Standard Mail Order Cost-Sharing - three Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this month supply Tier (Optional):

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SDE

Select all Long Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

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

Yes

supply for the first fill?

SECTION RX: TIER #5 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

\$15.00

Pharmacy one month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-**ICL**

Avg Expected Coins Dollar Amt Standard Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing three month supply:

\$15.00

Avg Expected Coins Dollar Amt Preferred Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing one month supply: Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing three month supply:

SECTION RX: TIER #5 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail Order Cost-Sharing three month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy one month supply:

25%

Indicate Coinsurance percentage for Long Term Care Pharmacy one month supply:

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SDE

SECTION RX: TIER #6 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

: Brand

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing three month supply

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

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30 Retail/Preferred Retail Cost-Sharing in your one

month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

Yes

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

No

supply for the first fill?

SECTION RX: TIER #6 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

\$6.00

Indicate Copayment amount for Standard Retail

Cost-Sharing one month supply:

Contrato Número

Indicate Copayment amount for Standard Retail \$12.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$1.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$2.00

Cost-Sharing three month supply:

SECTION RX: TIER #6 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

Order Cost-Sharing three month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

\$2.00

Indicate Copayment amount for Out-of-Network \$6.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term \$1.00

Care Pharmacy one month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.20 Daily Standard Retail Copayment \$0.03 Daily Preferred Retail Copayment \$0.03 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD Medicare-defined Post Threshold Cost Shares

How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

Contrato Númer

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description

Non-Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that

: Brand

apply):

Tier Includes:

Part D Drugs Only

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that

: Generic : Brand

apply):

Part D Drugs Only

Tier Includes:

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that

: Generic : Brand

apply):

Part D Drugs Only

Tier Includes:



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 026, SEGMENT 0

Module: PBP
Requested By: m660

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2019 PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 06/03/2019 04:25:48 PM SA Western Standard

Time

MA BPT Timestamp: 06/03/2019 08:14:52 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2019 06:05:35 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/03/2019 08:59:46 PM SA Western Standard

Time

Upload Status: 06/03/2019 #02479

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

SECTION .





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

Service Area(s): Service Area(s): TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Advance (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



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

Service Area(s)

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

40740 - Vieques, PR

40330 - Hormigueros, PR

POSDE

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	026
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member months for this plan:	13200
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.sssadvantage.c
Formulary Website Address:	www.sssadvantage.c
Physician Website Address:	www.sssadvantage.c

com com com (888)620-1919

(888)620-1919

(877)207-8777

(877)207-8777

(888)620-1919

(888)620-1919

(877)207-8777

(877)207-8777





SECTION A: SECTION A-4 Customer Service Contact Local Phone Number

Customer Service Contact Phone Number for

Customer Service Contact Local Phone Number

Customer Service Contact Local Phone Number

Customer Service Contact Local Phone Number

Customer Service Contact Phone Number for

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

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for

Current Medicare Beneficiaries:

for Current Medicare Beneficiaries:

Prospective Medicare Beneficiaries:

for Prospective Medicare Beneficiaries:

Current Part D Medicare Beneficiaries:

for Prospective Part D Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for	(866)620-2520	
Current Medicare Beneficiaries:		
Customer Service Contact Local TTY/TDD for	(866)620-2520	
Current Medicare Beneficiaries:	(0.6.6).600, 0.500	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for	(866)620-2520	
Prospective Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
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	No	
Section C of the PBP? SECTION A: SECTION A-6		
	No	
Is your organization filing a standard bid for Section D of the PBP?		
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	Yes	
Select the benefits that have tiered cost sharing:	: Medicare-covered	
Select the Medicare-covered benefits that have tiered cost sharing:	: 7f: Podiatry Services	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1		
Does the plan provide Inpatient Hospital-Acute	Yes	

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

C?

Select enhanced benefits:

Select type of benefit for Additional Days:

Is this benefit unlimited for Additional Days?

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

: Additional Days

Mandatory

Yes

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

obtains care?





Is there an enrollee Coinsurance?

No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains

No

care?

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required? Is a referral required for Inpatient HospitalΝo No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

No

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

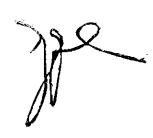
C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?





Is there a service-specific Maximum Enrollee No Contrato Número Out-of-Pocket Cost? **SECTION B: #2 SNF - BASE 2** Does this plan's Medicare-covered benefit cost No sharing vary by the Skilled Nursing Facility in which an enrollee obtains care? Νo Is there an enrollee Coinsurance? SECTION B: #2 SNF - BASE 6 No Is there an enrollee Copayment? SECTION B: #2 SNF - BASE 10 Per Admission or Per Stay What is your SNF benefit period? Do you charge cost sharing on the day of No discharge? Yes Is authorization required? Is a referral required for SNF Services? No SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1 Does the plan provide Cardiac and Pulmonary No Rehabilitation Services as a supplemental benefit under Part C? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3 No Is there an enrollee Deductible? No Is there an enrollee Copayment? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4 Yes Is authorization required? Is a referral required for Cardiac and Pulmonary No Rehabilitation Services? SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? SECTION B: #4A EMERGENCY CARE/POST-STABILIZATION CARE - BASE 2 Is there an enrollee Copayment? No Services in the USA may also be available Notes: through reimbursement in accordance with Medicare rates and the location where services were provided. SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

No

Nο

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there a service-specific Maximum Enrollee

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

Is there an enrollee Copayment?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

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

75.00

amount:

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 No Is there an enrollee Copayment? No

Is there an enrollee Deductible? SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:

Worldwide services are covered through

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No No

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

about:blank



Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

: Routine Care Select enhanced benefit:

Select type of benefit for Routine Care: Mandatory

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

Indicate number of visits for Routine Care:

Every year Select Routine Care periodicity: No

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Νo Is there an enrollee Coinsurance? Yes Is there an enrollee Copayment?

: Medicare-covered Chiropractic Services Select which Chiropractic Services have a

Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$2.00

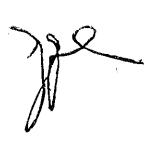
Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$2.00

Medicare-covered Benefits:

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

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



Contrato Número

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required? Is a referral required for Occupational Therapy No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required? Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Νo Is authorization required? Is a referral required for Mental Health No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Select type of benefit for Routine Foot Care: Mandatory No

Is this benefit unlimited for Routine Foot Care? Indicate number of Routine Foot Care visits: 4

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2





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

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

: Medicare-covered Podiatry Services

Indicate Minimum Copayment amount per visit

\$0.00

for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit

\$2.00

for Medicare-covered Benefits:

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

Notes:

\$0 copay for services rendered in SALUS

facility.

\$2 copay for Medicare covered services.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Nο Is authorization required? Is a referral required for Psychiatric Services? No

SECTION B: #7I PT AND SP SERVICES - BASE 1 No

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

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

SECTION B: #71 PT AND SP SERVICES - BASE 2

Yes Is authorization required?



Is a referral required for Physical Therapy and

No

Speech-Language Pathology Services?

Notes:

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

Do you offer an Additional Telehealth benefit

No

for Part B services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?





Is there an enrollee Coinsurance?

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

No

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

Is authorization required for Medicare-covered Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

No Is a referral required for Medicare-covered

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 3

Notes:

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

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

Is a referral required for Ambulatory Surgical No

Center Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

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

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

Abuse?

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

Does the plan provide Outpatient Blood

Services as a supplemental benefit under Part

C?

Select enhanced benefit:

: Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee

No

Yes

No





Out-of-Pocket Cost?

Νo Is there an enrollee Coinsurance?

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

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

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

20%

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services No as a supplemental benefit under Part C?

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance? 0%

Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Yes Is authorization required?

0% coinsurance for preferred brands and Notes:

manufacturers.

20% coinsurance for non preferred brands and

manufacturers.

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

: Medicare-covered Prosthetic Devices



a Coinsurance (Select all that apply):

: Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

20%

0%

0% 20%

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

Νo

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

Is authorization required?

Yes

Notes:

20% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for medical supplies preferred brands and manufacturers.20% coinsurance for medical supplies non preferred brands and manufacturers.

0% coinsurance for Cardiovascular Devices.

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

Νo

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

Is there an enrollee Copayment?

Do you limit Diabetic Supplies and Services to

Yes

those from specified manufacturers?

No

Is authorization required? SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No

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

Νo

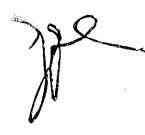
Is there an enrollee Copayment? SECTION B: #12 DIALYSIS SERVICES - BASE 2

No Is authorization required? No

Is a referral required for Dialysis Services?







SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

No

supplemental benefit under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

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

No

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

No

Is a referral required?

No

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

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Nutritional/Dietary Benefit

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

Hotline)*

: Counseling Services

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory

Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

4

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

: Nursing Hotline



Mandatory

Mandatory

Is this benefit unlimited for Counseling

Yes

Services?

Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Is there a service-specific Maximum Plan

Νo

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

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This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

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

Remote Access Technologies (Nursing Hotline) Notes:

Counseling Services Notes:

Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend,

economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

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

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered Preventive Services?

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

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

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

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

Glaucoma Screening?

Is authorization required for Medicare-covered No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

No

Is authorization required for Medicare-covered

No

No .

EKG following Welcome Visit?

Is authorization required for Other Medicare-

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance? Nο

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

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



about:blank

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

: Part B to Part B? : Part B to Part D?

apply):

: Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

Yes

drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

Yes

as a supplemental benefit under Part C?

: Oral Exams

Select enhanced benefits:

: Prophylaxis (Cleaning)

: Fluoride Treatment : Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory

Is this benefit unlimited for Oral Exams?

No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Every six months

Select type of benefit for Prophylaxis

Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

No, indicate number

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Mandatory

Select type of benefit for Fluoride Treatment:

Every six months

Is this benefit unlimited for Fluoride Treatment?

No, indicate number

Indicate number of visits for Fluoride

1

Treatment:

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Other, Describe

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4





Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

No

Is a referral required for Preventive Dental

No

Services?

Notes:

Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

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:

: Non-routine Services : Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Yes

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



Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

600.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes:

Restorative: Amalgams and Composites Resin restorations-every 24 month, Core build up and Pin retention-1 per tooth every 5 years,

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0 0

Protective restorations-1 treatment per tooth per life, Prefabricated stainless steel crown for primary teeth (baby teeth)-1 per tooth per life / Periodontics: Root Planning and curettage-1 per quadrant every two years, Full mouth debriment-1 every twelve month, Periodontal maintenance- 1 every six-month concluded periodontal therapy since the last prophylaxis / Endodontics-1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent. Root canal therapy for anterior teeth and bicuspids, Retreatments for anterior teeth and bicuspids 1 per tooth per life / Prosthodontic-The placement of Removable Prosthesis will be covered 1 per arch every 5 years: Adjustments-after the initial insertion all adjustments are included in the prosthesis fee up to 6 month, Repairs-3 repair codes in a period of 5 years per prosthesis, Rebase-1 per arch every 5 years, Relines-1 per arch every 5 year, Flexible base material not covered (valplast) /

Oral Surgery: Extraction of erupted tooth,

about:blank

exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue-1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

SECTION B: #17A EYE EXAMS - BASE 1

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

Select type of benefit for Routine Eye Exams: Is this benefit unlimited for Routine Eye Exams?

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C? Select enhanced benefits:

M M

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

Every year

No

No

No

No

No

No

No

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses





: Eyeglass frames ; Upgrades Mandatory Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes Mandatory Select type of benefit for Eyeglasses (lenses and frames): Is this benefit unlimited for Eyeglasses (lenses Yes and frames)? SECTION B: #17B EYEWEAR - BASE 2 Mandatory Select type of benefit for Eyeglass lenses: Is this benefit unlimited for Eyeglass lenses? Yes Select type of benefit for Eyeglass frames: Mandatory Is this benefit unlimited for Eyeglass frames? Yes Mandatory Select type of benefit for Upgrades: **SECTION B: #17B EYEWEAR - BASE 3** Yes Is there a service-specific Maximum Plan Benefit Coverage amount? Plan-specified amount per period Select the Maximum Plan Benefit Coverage type: Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 100.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Contrato Número No Is there an enrollee Coinsurance? SECTION B: #17B EYEWEAR - BASE 5 No Is there an enrollee Deductible? No Is there an enrollee Copayment? SECTION B: #17B EYEWEAR - BASE 6 No Is authorization required? Νo Is a referral required for Eyewear? SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? : Routine Hearing Exams Select enhanced benefits: Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams?

1

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity: Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment? No

Is authorization required? No Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a No

supplemental benefit under Part C?

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

Does your plan include MA Uniformity No

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for No

the Chronically III?

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?

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

Yes

Yes

: In-Network Medicare-covered benefits

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

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

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of- 3400.00

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage No

Amount?

about:blank

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription Yes

drug (Part D) benefit?





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Select the type of drug benefit:

Describe the components of your network (select all that apply):

Actuarially Equivalent Standard

: Standard/Preferred Retail Cost-Sharing

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42 CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

OTC Medication Attestation statement

Yes

No

Yes

Yes

No

Yes

Yes

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

What is your Formulary Exception Tier?

Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions? Yes

6 4

No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan: Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

sharing structure

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Cost Share Tiers

Initial Coverage Limit (ICL) is reached?

SECTION RX: TIER #1 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Generic

Tier Includes: Part D Drugs Only

Indicate the type of cost sharing structure: Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

three month supply : Out-of-Network Pharmacy - one month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

one month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Standard Retail/Preferred Retail Cost-Sharing -

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

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

supply for the first fill?

Yes

No

SECTION RX: TIER #1 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

90 Enter number of days for Standard Mail Order

Cost-Sharing in your three month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

30

Pharmacy one month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

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Indicate Copayment amount for Standard Retail Cost-Sharing one month supply:	\$19.00
Indicate Copayment amount for Standard Retail	\$38.00
Cost-Sharing three month supply: Indicate Copayment amount for Preferred Retail	\$14.00
Cost-Sharing one month supply: Indicate Copayment amount for Preferred Retail	\$28.00



SECTION RX: TIER #1 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$28.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$19.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$14.00

Care Pharmacy one month supply:

Cost-Sharing three month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.63 Daily Standard Retail Copayment \$0.47 Daily Preferred Retail Copayment Daily Copayment for Long Term Care \$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Generic

Part D Drugs Only Tier Includes:

Indicate the type of cost sharing structure: Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

month supply

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

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one month supply:





Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

Cost-Sharing in your three month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

Pharmacy one month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-**ICL**

Yes

No

90

31

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing one month supply:

\$40.00 Indicate Copayment amount for Standard Retail

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #2 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

\$30.00

\$15.00

Indicate Copayment amount for Standard Mail

Order Cost-Sharing three month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

Care Pharmacy one month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.67

\$0.50 Daily Preferred Retail Copayment

\$0.48 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply):

Part D Drugs Only Tier Includes:

Copayment Indicate the type of post sharing structure:



Contrato Número

POSDE

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing three month supply

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

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30 Retail/Preferred Retail Cost-Sharing in your one month supply:

90 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

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

Yes No

SECTION RX: TIER #3 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order Cost-Sharing in your three month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

30

90

Pharmacy one month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$47.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

Cost-Sharing three month supply:

\$94.00

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing three month supply:

SECTION RX: TIER #3 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail \$84.00

6/4/2019 about:blank

Order Cost-Sharing three month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$42.00

Care Pharmacy one month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$1.57 Daily Standard Retail Copayment \$1.40 Daily Preferred Retail Copayment Daily Copayment for Long Term Care \$1.35

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Brand

Part D Drugs Only Tier Includes: Copayment' Indicate the type of cost sharing structure:

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Prefefred Retail Cost-Sharing -

three month supply : Out-of-Network Pharmacy - one month supply

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

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

ISTRACION

Contrato Número

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your one

month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your three month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply? Are any of the drugs available at an extended

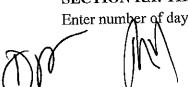
day supply for this tier limited to a 1-month supply for the first fill?

Yes

Yes

SECTION RX: TIER #4 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order 90



Contrato Número

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Posp

Cost-Sharing in your three month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing three month supply:

SECTION RX: TIER #4 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$190.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$95.00

Care Pharmacy one month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$3.33 Daily Standard Retail Copayment \$3.17 Daily Preferred Retail Copayment \$3.06 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICI

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

: Out-of-Network Pharmacy - one month supply

Tier:

: Standard Mail Order Cost-Sharing - three

Select all Standard Mail Order Cost-Sharing

Location/supply amount(s) that apply for this

Tier (Optional):

month supply

: Long Term Care Pharmacy - one month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply? Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

Yes

supply for the first fill?

SECTION RX: TIER #5 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

Avg Expected Coins Dollar Amt Standard

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing three month supply:

25%

Avg Expected Coins Dollar Amt Preferred

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing three month supply:

SECTION RX: TIER #5 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail Order Cost-Sharing three month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy one month supply:

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Contrato Número

POSDE

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Indicate Coinsurance percentage for Long Term

Care Pharmacy one month supply:

SECTION RX: TIER #6 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

25%

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic : Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

: Standard Retail/Preferred Retail Cost-Sharing one month supply

Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

that apply for this Tier:

: Out-of-Network Pharmacy - one month supply

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

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

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

Contrato Número

Post

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one month supply:

Tier:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

No

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

supply for the first fill?

SECTION RX: TIER #6 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

31

Pharmacy in your one month supply:

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

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

Cost-Sharing one month supply:

\$20.00

Indicate Copayment amount for Standard Retail

\$40.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #6 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$30.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$15.00

Care Pharmacy one month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment

\$0.67

Daily Preferred Retail Copayment

\$0.50

Daily Copayment for Long Term Care

\$0.48

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the

Medicare Part D Annual Out-of-Pocket Cost

Medicare-defined Post Threshold Cost Shares

Contrato Número

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP 1

: Generic Select drug type(s) in this Tier (select all that

apply):

Part D Drugs Only Tier Includes: SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Generic

Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

2 Tier ID - OOP

: Generic Select drug type(s) in this Tier (select all that

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

3 Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic : Brand apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Select Care Drugs Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic : Brand

apply):

Part D Drugs Only Tier Includes:



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

PBP

m660

DATA REPORT FOR Contract H5774, PLAN 028, SEGMENT 0

Module:
Requested By:

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2019

PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 06/03/2019 04:28:27 PM SA Western Standard

Time

MA BPT Timestamp: 06/03/2019 08:16:20 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2019 06:06:37 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/03/2019 08:59:46 PM SA Western Standard

Time

Upload Status: 06/03/2019 #02479

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Section B7 Status

Completed

Section 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 StatusCompletedSection B15 StatusCompletedSection B16 StatusCompleted

Section B17 Status Completed
Section B18 Status Completed

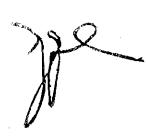
Section B18 Status Completed
Section B19 Status Completed

Section C Status Completed
Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1

M





Organization Legal Name:

Organization Marketing Name:

Organization Web Site:

Plan Name:

Organization Type:

Plan Type:

Enrollee Type:

Service Area(s):

TRIPLE S ADVANTAGE, INC.

Triple S Advantage

www.sssadvantage.com

Platino Blindao (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

40030 - Aguadilla, PR

40040 - Aguas Buenas, PR

40050 - Aibonito, PR

40060 - Anasco, PR

40070 - Arecibo, PR

40080 - Arroyo, PR

40090 - Barceloneta, PR

40100 - Barranquitas, PR

40110 - Bayamon, PR

40120 - Cabo Rojo, PR

40130 - Caguas, PR

40140 - Camuy, PR

40145 - Canovanas, PR

40150 - Carolina, PR

40160 - Catano, PR

40170 - Cayey, PR

40180 - Ceiba, PR

40190 - Ciales, PR

40200 - Cidra, PR

40210 - Coamo, PR

40220 - Comerio, PR

40230 - Corozal, PR

40240 - Culebra, PR

40250 - Dorado, PR

40260 - Fajardo, PR

40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



Service Area(s): 40330 - Hormigueros, PR 40340 - Humacao, PR

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

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR



Service Area(s):

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	028
Segment ID:	0
Contract Period:	2020
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2020 total projected member	120348
months for this plan:	
Does this Plan have a CMS-approved	No
Continuation Area?	V _{o.a}
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	No
sharing plan (this does not apply to Part D	
Services)?	
Under this D-SNP, has the state agreed to cover	No
all Medicare premiums and cost sharing for	
enrollees in your D-SNP?	

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(888)620-1919

(877)207-8777

(877)207-8777

(888)620-1919

(888)620-1919

(877)207-8777

(877)207-8777

Physician Website Address: Customer Service Contact Phone Number for

Participating Pharmacy Website Address:

SECTION A: SECTION A-3

Formulary Website Address:

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:

Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:

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

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

Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number



for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
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	

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

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

Yes

Select enhanced benefits: Select type of benefit for Additional Days: : Additional Days

Mandatory

Is this benefit unlimited for Additional Days?

Yes

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 No

No

obtains care?

Is there an enrollee Coinsurance?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing

No





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

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

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

No

Do you allow less than 3 day inpatient hospital

Νo

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

No Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

No

Does the plan provide Cardiac and Pulmonary No Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

No

Yes Is authorization required? Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

No Is there an enrollee Copayment?

Services in the USA may also be available Notes: through reimbursement in accordance with

Medicare rates and the location where services

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Nο Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment? No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

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Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

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:

75.00

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?

No

Is there an enrollee Deductible?

No

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

Notes:

Worldwide services are covered through

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2





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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Νo

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care Select enhanced benefit:

Mandatory Select type of benefit for Routine Care:

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

Indicate number of visits for Routine Care:

Every year Select Routine Care periodicity: No

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both? Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

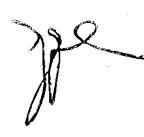
SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Yes Is authorization required? No

Is a referral required for Occupational Therapy

Services?

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





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Yes Is authorization required? Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Yes

No

No

No

No Is authorization required? No Is a referral required for Mental Health

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 4

Every year Select the Routine Foot Care periodicity: No

Is there a service-specific Maximum Plan

Benefit Coverage amount?

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

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

No Is authorization required? 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?

Is there an enrollee Coinsurance?

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No Is there an enrollee Deductible? No Is there an enrollee Copayment? SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2 No Is authorization required? Is a referral required for Other Health Care Yes Professional Services? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 No Is there an enrollee Coinsurance? No Is there an enrollee Deductible?

Is there an enrollee Copayment? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

No Is authorization required? Is a referral required for Psychiatric Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

No Is there an enrollee Copayment?

SECTION B: #71 PT AND SP SERVICES - BASE 2

Yes Is authorization required? No

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Ňο

Do you offer an Additional Telehealth benefit No for Part B services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Services?

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

No

Is there a service-specific Maximum Enrollee

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

Out-of-Pocket Cost?



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Is there an enrollee Coinsurance?

Nο

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered

Yes

Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 3

Notes:

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #9B ASC SERVICES - BASE 2



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

Is a referral required for Ambulatory Surgical

Center Services?

SECTION B: #9B ASC SERVICES - BASE 3

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

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

Abuse?

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

Yes Does the plan provide Outpatient Blood Services as a supplemental benefit under Part

C?

: Three (3) Pint Deductible Waived Select enhanced benefit:

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3







Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Select enhanced benefit:

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

Select Type of Transportation for Plan

Approved Health-related Location:

Select Mode of Transportation for Plan

Approved Health-related Location:

Yes

Yes

Plan Approved Health-related Location

Other method of transportation is available in an

automobile through a contracted provider.

Mandatory

No

20

Every year

One-way

: Taxi

: Van

No

No

Νo

10%

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

Notes:

SECTION B: #11A DME - BASE 1 Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance? 0%

Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

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Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Yes

Yes

Is authorization required?

Notes:

0% coinsurance for preferred brands and

manufacturers.

10% coinsurance for non preferred brands and

manufacturers.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Yes

Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

a Coinsurance (Select all that apply):

0%

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

10%

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

0%

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

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?

Νo

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

Is authorization required?

Yes

Notes:

10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for medical supplies preferred brands and manufacturers.10% coinsurance for medical supplies non preferred brands and manufacturers.

0% coinsurance for Cardiovascular Devices.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

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

Is there an enrollee Copayment?

No





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	Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
	Is authorization required?	No
	SECTION B: #12 DIALYSIS SERVICES - BASE	E 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 - BAS	E 2
	Is authorization required?	No
	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:	12
	Indicate Number of Treatments 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 No.
	Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes $\begin{pmatrix} \begin{pmatrix} \text{Contrato Notinero} \\ 2 & 0 & 0 & 1 \end{pmatrix} \end{pmatrix}$
	SECTION B: #13A ACUPUNCTURE - BASE 2	
	Is there an enrollee Coinsurance?	No No
	Is there an enrollee Deductible?	No No
	Is there an enrollee Copayment?	No
	Is authorization required?	No
	Is a referral required for Acupuncture?	No
	SECTION B: #13A ACUPUNCTURE - BASE 3	
	Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.
	SECTION B: #13B OTC ITEMS - BASE 1	
ı	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

M

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Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

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

Nicotine Replacement Therapy (NRT)
Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

40.00

Every three months

No

No

Yes

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

No

No

No

No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, . Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

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





Is authorization required?

No

Is a referral required?

No

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

Does the plan provide the Annual Physical

Nο

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Nutritional/Dietary Benefit

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

Hotline)*

: Counseling Services : Alternative Therapies*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary

Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Individual Sessions

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

Mandatory

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Select type of benefit for Counseling Services:

Mandatory

Is this benefit unlimited for Counseling Services?

Yes

Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

Is your Alternative Therapies benefit combined

Yes

with either the Chiropractor Services benefit or

Acupuncture benefit, or both?

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

Is there a service-specific Maximum Plan

No



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00

20-

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

Νo

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:





This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

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

Remote Access Technologies (Nursing Hotline)

Notes:

Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate

available community services.

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

Alternative Therapies Notes:*

Counseling Services Notes:

Services are subject to the combined maximum





limit with Acupuncture benefits. Alternative therapies include:

- Chinese Medicine
- Pranic Healing
- Music Therapy
- Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues)
- Naturopathic Medicine
- Traditional Chinese Medicine
- Reflexology

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

No

Glaucoma Screening?

No

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered **Barium Enemas?**

Νo

No

Is authorization required for Medicare-covered

Digital Rectal Exams?

No

Is authorization required for Medicare-covered

EKG following Welcome Visit?

No

Is authorization required for Other Medicarecovered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment? No

No Is there an enrollee Deductible? Yes

Is Authorization Required? Yes Does the plan offer step therapy?

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

apply): : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

Yes

Yes

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

: Oral Exams Select enhanced benefits:

: Prophylaxis (Cleaning) : Fluoride Treatment

: Dental X-Rays

No, indicate number

No, indicate number

Every six months

Mandatory

Mandatory

Select type of benefit for Oral Exams:

Is this benefit unlimited for Oral Exams?

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Select type of benefit for Prophylaxis

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Select type of benefit for Fluoride Treatment:

Is this benefit unlimited for Fluoride Treatment?

Indicate number of visits for Fluoride

Treatment:

Every six months

Mandatory

No, indicate number

1

1

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Mandatory

No, indicate number

1

Other, Describe





Is there a service-specific Maximum Plan

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

Is a referral required for Preventive Dental No

Services?

Notes: Up to (1) Panoramic image or Intraoral

No

No

complete series including bitewings, every three years. Once the member has used the Panoramic

images or Intraoral complete series, the

radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits:

Yes

: Non-routine Services

: Diagnostic Services : Restorative Services

: Endodontics

: Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Is this benefit unlimited for Non-routine

Services?

Select type of benefit for Diagnostic Services:

Is this benefit unlimited for Diagnostic

Services?

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Services?

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Mandatory





Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1500.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes:

Restorative: Amalgams and Composites Resin restorations-every 24 month, Core build up and Pin retention-1 per tooth every 5 years, Protective restorations-1 treatment per tooth per

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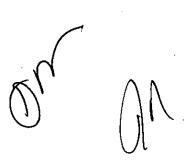
primary teeth (baby teeth)-1 per tooth per life / Periodontics: Root Planning and curettage-1 per quadrant every two years, Full mouth debriment-1 every twelve month, Periodontal maintenance- 1 every six-month concluded periodontal therapy since the last prophylaxis /

life, Prefabricated stainless steel crown for

Endodontics-1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent. Root canal therapy for anterior teeth and bicuspids, Retreatments for anterior teeth

and bicuspids 1 per tooth per life /

Prosthodontic-The placement of Removable





SECTION B: #17A EYE EXAMS - BASE 1

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

Select type of benefit for Routine Eye Exams: Is this benefit unlimited for Routine Eye Exams?

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

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

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

SECTION B: #17A EYE EXAMS - BASE 2

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

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

Is authorization required?

Is a referral required for Eye Exams?

Notes:

Prosthesis will be covered 1 per arch every 5 years: Adjustments-after the initial insertion all adjustments are included in the prosthesis fee up to 6 month, Repairs-3 repair codes in a period of 5 years per prosthesis, Rebase-1 per arch every 5 years, Relines-1 per arch every 5 year, Flexible base material not covered (valplast) / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue-1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

Every year

No

No

No

No

No

No

No

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.



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SECTION B: #17B EYEWEAR - BASE 1

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

Yes

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Select type of benefit for Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses?

Yes

Select type of benefit for Eyeglasses (lenses and

Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:

Mandatory

Is this benefit unlimited for Eyeglass lenses?

Yes

Select type of benefit for Eyeglass frames:

Mandatory

Is this benefit unlimited for Eyeglass frames?

Yes

Select type of benefit for Upgrades:

Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

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

500.00

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Every year

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

No

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

No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

No

Is a referral required for Eyewear?

No

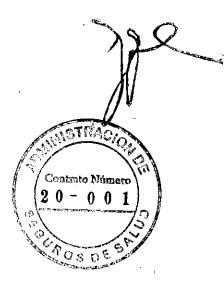
SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

Yes

supplemental benefit under Part C?

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

SECTION B: #18B HEARING AIDS - BASE 2 Is there a service-specific Maximum Plan

Is this benefit unlimited for Hearing Aids (all

Benefit Coverage amount?

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

combined?

Select the Maximum Plan Benefit Coverage

types):

types)?

Indicate Maximum Plan Benefit Coverage

amount

Plan-specified amount per period

Both ears combined

1500.00

Yes

Yes



Every year Indicate Maximum Plan Benefit Coverage periodicity: SECTION B: #18B HEARING AIDS - BASE 3 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? SECTION B: #18B HEARING AIDS - BASE 4 No Is there an enrollee Copayment? No Is there an enrollee Deductible? SECTION B: #18B HEARING AIDS - BASE 5 No Is authorization required? Is a referral required for Hearing Aids? No SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI Does your plan include MA Uniformity No Flexibility with reductions in cost or additional benefits? Do you offer Special Supplemental Benefits for No the Chronically III? SECTION C: V/T - GENERAL - US Do you offer a US Visitor/Travel Program? No SECTION D: PLAN DEDUCTIBLE (IN-NETWORK) Is there an In-Network Plan Deductible? No SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK) Is there an In-Network Maximum Enrollee Out-Yes of-Pocket Cost? Is your In-Network Maximum Enrollee Out-of-Voluntary Pocket (MOOP) Cost at the Voluntary or Mandatory Level? Indicate In-Network Maximum Enrollee Out-of-3400.00 Pocket Cost Amount: : In-Network Medicare-covered benefits Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost: Does the In-Network Maximum Enrollee Out-Yes of-Pocket Cost apply to all In-Network Medicare-covered plan services? SECTION D: MAX PLAN BENEFIT COVERAGE Is there a Maximum Plan Benefit Coverage No Amount? Contrata Namero SECTION RX: MEDICARE RX GENERAL 1 Does your plan offer a Medicare Prescription Yes drug (Part D) benefit? Actuarially Equivalent Standard Select the type of drug benefit: : Standard/Preferred Retail Cost-Sharing Describe the components of your network : Out-of-Network Pharmacy (select all that apply):

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

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

Yes Does plan utilize floor pricing? No Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription Yes

drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

OTC Medication Attestation statement

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6 4 What is your Formulary Exception Tier? Do you apply a second less expensive cost No

sharing level for all generic drugs approved for formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D

Yes

Yes

No

Yes

Yes



ahout:blank

SECTION RX: TIER #1 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Preferred Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

one month supply

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

Tier:

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

supply for the first fill?

SECTION RX: TIER #1 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$38.00

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Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing three month supply:

SECTION RX: TIER #1 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$28.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$14.00

Care Pharmacy one month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment

\$0.63

Daily Preferred Retail Copayment

\$0.47

Daily Copayment for Long Term Care

\$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing

Tier (Optional):

Location/supply amount(s) that apply for this

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICI

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your three month supply:

90

30





three month

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$40.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #2 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$30.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICI

Indicate Copayment amount for Out-of-Network

\$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$15.00

Care Pharmacy one month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.67 Daily Standard Retail Copayment \$0.50 Daily Preferred Retail Copayment

Daily Copayment for Long Term Care

\$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST SHARE STRUCTURE - PRI

Tier Label Description

Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

: Standard Retail/Preferred Retail Cost-Sharing -

Contrato Nú**mero**

Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

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

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing

: Standard Mail Order Cost-Sharing - three month supply

Location/supply amount(s) that apply for this Tier (Optional):

: Long Term Care Pharmacy - one month supply

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this

Tier:

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

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

No

Yes

supply for the first fill?

SECTION RX: TIER #3 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

30

Pharmacy one month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$47.00 Cost-Sharing one month supply: Indicate Copayment amount for Standard Retail \$94.00 Cost-Sharing three month supply: \$42.00

Indicate Copayment amount for Preferred Retail

Cost-Sharing one month supply: Indicate Copayment amount for Preferred Rétail

\$84.00

Cost-Sharing three month supply:

SECTION RX: TIER #3 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$84.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL



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Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term \$42.00

Care Pharmacy one month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$1.57 Daily Standard Retail Copayment \$1.40 Daily Preferred Retail Copayment \$1.35 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply): : Brand

Part D Drugs Only Tier Includes:

Copayment Indicate the type of cost sharing structure: SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your one

month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your three month supply:

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

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

Yes

Yes

supply for the first fill? SECTION RX: TIER #4 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order 90 Cost-Sharing in your three month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL



Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing three month supply:

SECTION RX: TIER #4 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$190.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$95.00

Care Pharmacy one month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICI

Daily Standard Retail Copayment

\$3.33

Daily Preferred Retail Copayment

\$3.17

Daily Copayment for Long Term Care

\$3.06

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing-

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three month supply

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Select all Long Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

Are any of the drugs available at an extended

Yes

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #5 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Avg Expected Coins Dollar Amt Standard

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing three month supply:

\$15.00

Avg Expected Coins Dollar Amt Preferred

Ψ15.00

Retail Cost-Sharing (1 month supply) (\$):

25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing three month supply:

SECTION RX: TIER #5 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail Order Cost-Sharing three month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy one month supply:

Indicate Coinsurance percentage for Long Term 25%

Care Pharmacy one month supply:

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SECTION RX: TIER #6 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic : Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

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

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this : Standard Mail Order Cost-Sharing - three month supply

Tier (Optional): Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

Tier: SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

supply for the first fill?

SECTION RX: TIER #6 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

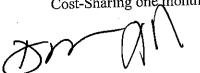
Pharmacy one month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$8.00

Cost-Sharing one month supply:



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\$16.00 Indicate Copayment amount for Standard Retail

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$3.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$6.00

Cost-Sharing three month supply:

SECTION RX: TIER #6 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$6.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$8.00

Pharmacy one month supply:

\$3,00 Indicate Copayment Amount for Long Term

Care Pharmacy one month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.27 Daily Standard Retail Copayment \$0.10 Daily Preferred Retail Copayment

\$0.10 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

Medicare-defined Post Threshold Cost Shares How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply): Tier Includes:

Part D Drugs Only

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

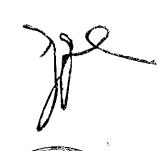
Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier ID - OOP : Brand

Select drug type(s) in this Tier (select all that apply):

Part D Drugs Only



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SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):

Tier Includes: Part D Drugs Only

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Specialty Tier

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Select Care Drugs

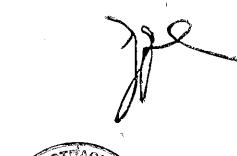
Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP 6

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only





Dr. M

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 032, SEGMENT 0

Module: PBP

Requested By: m660

PLAN SYSTEM INFORMATION

Last entry Date: 06/03/2019
PBP Software Version: 2020.01

Plan Ready for Upload Timestamp: 06/03/2019 04:30:38 PM SA Western Standard

Time

MA BPT Timestamp: 06/03/2019 08:17:47 PM SA Western Standard

Time

PD BPT Timestamp: 06/03/2019 06:07:36 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/03/2019 08:59:46 PM SA Western Standard

Time

Upload Status: 06/03/2019 #02479

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Completed

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 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





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

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Enlace (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR 40280 - Guayama, PR

40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR



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

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

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

> 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR 40720 - Vega Alta, PR

40730 - Vega Baja, PR 40740 - Vieques, PR



		40750 - Villalba, PR
	Service Area(s):	40760 - Yabucoa, PR
	Service Area(s):	40770 - Yauco, PR
	Contract Number:	H5774
	Plan ID:	032
	Segment ID:	0
	Contract Period:	2020
	Plan Geographic Name:	Puerto Rico
	Is this an Employer-Only plan?	No
	SECTION A: SECTION A-2	- 1-
	Indicate CY2020 total projected member	8400
	months for this plan:	
	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.sssadvantage.com
	Formulary Website Address:	www.sssadvantage.com
	Physician Website Address:	www.sssadvantage.com
•	Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
	Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
	Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
	Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
	Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
	Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
/	Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-4	(877)207-8777
	Customer Service Contact Local Phone Number	(877)207-8777
	_	

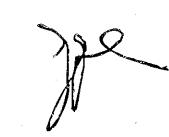




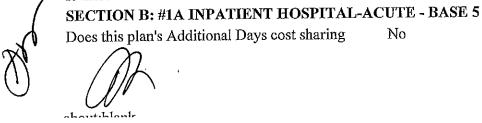
for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
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-A	CUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - 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

No

No







Is there an enrollee Coinsurance?

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

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

No

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

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

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

obtains care?

Is there an enrollee Coinsurance?

Nο

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part

No

Do you allow less than 3 day inpatient hospital

Νo

stay prior to SNF admission? Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

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 No

No

Is a referral required for SNF Services?

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

Does the plan provide Cardiac and Pulmonary

-9

Rehabilitation Services as a supplemental benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

Νo

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Νo

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

Is there an enrollee Copayment?

No

Notes:

Services in the USA may also be available

through reimbursement in accordance with Medicare rates and the location where services

were provided.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3



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Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

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

75.00

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

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

Notes:

Worldwide services are covered through

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

No

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?

Is a referral required for Home Health Services? No

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

Yes

No

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Occupational Therapy No

Services?

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





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? Ň٥

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

Is authorization required?

Yes

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

Is authorization required?

No

Is a referral required for Mental Health

No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Foot Care

Select type of benefit for Routine Foot Care:

Mandatory

Is this benefit unlimited for Routine Foot Care? Indicate number of Routine Foot Care visits:

No

Every year

Select the Routine Foot Care periodicity:

No

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

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

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee

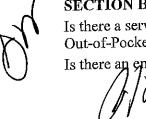
No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No







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

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

Is authorization required?

No

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

No Is authorization required?

Is a referral required for Psychiatric Services? No

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

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

Yes Is authorization required? No

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit No

for Part B services?

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

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

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

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

No Is authorization required?

No Is a referral required for Opioid Treatment

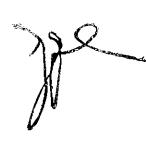
Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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



Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

Nο

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered

Yes

Observation Services?

Is a referral required for Medicare-covered

No

Outpatient Hospital Services?

Is a referral required for Medicare-covered

No

No

Observation Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 3

Notes:

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #9B ASC SERVICES - BASE 2





Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?

Is a referral required for Ambulatory Surgical

No

Center Services?

SECTION B: #9B ASC SERVICES - BASE 3

Notes:

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

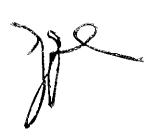
Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

M





Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Plan Approved Health-related Location Select enhanced benefit:

Yes

Yes

No

Mandatory

Every year

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

18 Indicate number of trips for Plan Approved

Health-related Location:

Select Plan Approved Health-related Location

Trips periodicity:

One-way

Select Type of Transportation for Plan Approved Health-related Location:

Select Mode of Transportation for Plan : Taxi : Van Approved Health-related Location:

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

Other method of transportation is available in an Notes: automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance?

0% Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2



Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required?

Notes:

Yes

Yes

0% coinsurance for preferred brands and

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

manufacturers.

10% coinsurance for non preferred brands and

manufacturers.

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Yes

Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

0%

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

0%

10%

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

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?

Vec

Notes:

10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0%

coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for medical supplies preferred brands and manufacturers.10% coinsurance for medical supplies non preferred brands and manufacturers.

0% coinsurance for Cardiovascular Devices.

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

Is there a service-specific Maximum Enrollee

__

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

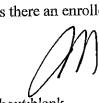
Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

Νo





Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
SECTION B: #12 DIALYSIS SERVICES - BAS	SE 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 - BA	SE 2
Is authorization required?	No
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:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No Contrato Número
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	$\begin{pmatrix} 0 & 0 & 0 & 1 \\ 0 & 0 & 0 & 1 \\ 0 & 0 & 0 & 1 \end{pmatrix}$
SECTION B: #13A ACUPUNCTURE - BASE	2 No
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 Acupuncture?	No
SECTION B: #13A ACUPUNCTURE - BASE	3
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.
SECTION B: #13B OTC ITEMS - BASE 1	•

Yes

Yes

Mandatory

D/

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

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Benefit Coverage amount?

Is there a service-specific Maximum Plan

6/4/2019

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

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

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

Nicotine Replacement Therapy (NRT)

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

250.00

Every three months

No

No

Yes

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

No

No

No

No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatologicals, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood

The Blood Pressure Monitor is covered up t

one (1) every 5 years.

Pressure Monitor.

SECTION B: #13C MEAL BENEFIT - BASE 1

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

SECTION B: #13D OTHER 1 - BASE 1

Enter name of Service (Optional): Select type of benefit for Other 1:

Is there a service-specific Maximum Plan

No

Extended Care Package (La Ñapa)

Mandatory

No



Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13D OTHER 1 - BASE 2

Is there an enrollee Coinsurance?

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

Is authorization required?

Is a referral required for Other Services?

SECTION B: #13D OTHER 1 - BASE 3

Notes:

No

No

No

No

No

No

'Member may choose to add, at zero (\$0) extra cost, only one of the following supplemental benefits:

Eyewear - Up to \$175 per year as an added allowance value to the standard supplemental eyewear benefit. Benefit follows the same restrictions as the standard supplemental benefit. Transportation - Up to 12 trips per year as an added benefit to the standard supplemental benefit. Benefit follows the same restrictions as the standard supplemental benefit. Dental - Up to \$500 per year as an added allowance value to the standard supplemental comprehensive dental benefit. Benefit follows the same restrictions as the standard supplemental benefit.

Hearing Aid- Up to \$1,000 per year as an added allowance value to the standard supplemental hearing aid benefit. Benefit follows the same restrictions as the standard supplemental benefit. OTC - Up to \$25 every 3 months as an added allowance value to the standard supplemental OTC benefit. Benefit follows the same restrictions as the standard supplemental benefit.

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.

No No

Is authorization required?

Is a referral required?

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

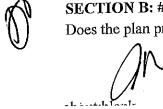
Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Yes



Supplemental Benefits as a benefit under Part

Select enhanced benefit (Select all that apply):

: Health Education

: Nutritional/Dietary Benefit

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

Hotline)*

: Counseling Services : Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Mandatory

Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

4

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Mandatory

Mandatory

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Yes

Services?

Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

12

Is your Alternative Therapies benefit combined

with either the Chiropractor Services benefit or

Yes

No

Acupuncture benefit, or both?

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

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

Νo

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9





Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

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

Remote Access Technologies (Nursing Hotline) Notes:

Counseling Services Notes

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Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home. Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

Alternative Therapies Notes:*

Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include:

- Chinese Medicine
- Pranic Healing
- · Music Therapy
- Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and

Mr.

learning disorders and communication issues)

Naturopathic Medicine

• Traditional Chinese Medicine

Reflexology

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

No

Glaucoma Screening?

No

Is authorization required for Medicare-covered

INO

Diabetes Self-Management Training?

No

Is authorization required for Medicare-covered Barium Enemas?

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

NT.

Is authorization required for Medicare-covered

EKG following Welcome Visit?

No

Is authorization required for Other Medicare-

No

covered Preventive Services?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No



about:blank

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that

: Part B to Part B? : Part B to Part D?

apply):

: Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Doés the plan provide Part D home infusion

Yes

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

Yes

as a supplemental benefit under Part C?

: Oral Exams

Select enhanced benefits:

: Prophylaxis (Cleaning) : Fluoride Treatment

: Dental X-Rays

Select type of benefit for Oral Exams:

Mandatory

Is this benefit unlimited for Oral Exams?

No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Every six months

Select type of benefit for Prophylaxis

Mandatory

(Cleaning):

No, indicate number

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Every six months

Select type of benefit for Fluoride Treatment:

Mandatory

Is this benefit unlimited for Fluoride Treatment?

No, indicate number

Indicate number of visits for Fluoride

1

Treatment:

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Other, Describe

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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0 0

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

No

Is a referral required for Preventive Dental

Nο

Services?

Notes:

Up to (1) Panoramic image or Intraoral

complete series including bitewings, every three years. Once the member has used the Panoramic

images or Intraoral complete series, the

radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

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:

: Non-routine Services

: Diagnostic Services : Restorative Services

: Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Mandatory

Oral/Maxillofacial Surgery, Other Services:

Yes

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





Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes:

Restorative: Amalgams and Composites Resin restorations-every 24 month, Core build up and Pin retention-1 per tooth every 5 years, Protective restorations-1 treatment per tooth per life, Prefabricated stainless steel crown for primary teeth (baby teeth)-1 per tooth per life / Periodontics: Root Planning and curettage-1 per quadrant every two years, Full mouth debriment-1 every twelve month, Periodontal maintenance- 1 every six-month concluded periodontal therapy since the last prophylaxis / Endodontics-1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent. Root canal therapy for anterior teeth and bicuspids, Retreatments for anterior teeth and bicuspids 1 per tooth per life / Prosthodontic-The placement of Removable Prosthesis will be covered 1 per arch every 5 years: Adjustments-after the initial insertion all adjustments are included in the prosthesis fee up

to 6 month, Repairs-3 repair codes in a period of 5 years per prosthesis, Rebase-1 per arch every

5 years, Relines-1 per arch every 5 year, Flexible base material not covered (valplast) / Oral Surgery: Extraction of erupted tooth,

De



ahout:blank

SECTION B: #17A EYE EXAMS - BASE 1

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

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits:

exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

Every year

No

No

No

No

No

No

No

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

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Yes

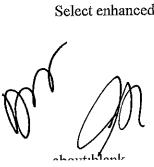
: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses

: Eyeglass frames

: Upgrades



Mandatory Select type of benefit for Contact lenses: Is this benefit unlimited for Contact lenses? Yes Select type of benefit for Eyeglasses (lenses and Mandatory frames): Is this benefit unlimited for Eyeglasses (lenses Yes and frames)? **SECTION B: #17B EYEWEAR - BASE 2** Mandatory Select type of benefit for Eyeglass lenses: Is this benefit unlimited for Eyeglass lenses? Yes Mandatory Select type of benefit for Eyeglass frames: Yes Is this benefit unlimited for Eyeglass frames? Select type of benefit for Upgrades: Mandatory **SECTION B: #17B EYEWEAR - BASE 3** Is there a service-specific Maximum Plan Yes Benefit Coverage amount? Plan-specified amount per period Select the Maximum Plan Benefit Coverage type: Yes Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 200.00 Coverage amount: Every year Select the Combined Maximum Plan Benefit Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance? **SECTION B: #17B EYEWEAR - BASE 5** No Contrato Númer Is there an enrollee Deductible? No Is there an enrollee Copayment? SECTION B: #17B EYEWEAR - BASE 6 No Is authorization required? Is a referral required for Eyewear? No SECTION B: #18A HEARING EXAMS - BASE 1 Yes Does the plan provide Hearing Exams as a supplemental benefit under Part C? : Routine Hearing Exams Select enhanced benefits: : Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: No, indicate number Is this benefit unlimited for Routine Hearing Exams? Indicate number for Routine Hearing Exams: Select Routine Hearing Exams periodicity: Every year

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	E 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	E 3
Is there an enrollee Copayment?	No
Is authorization required?	No
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 year Every year
SECTION B: #18B HEARING AIDS - BASE 3	$\begin{pmatrix} \text{Contrato Número} \\ 2 & 0 & 0 & 1 \end{pmatrix}$
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No (m)
Is there an enrollee Coinsurance? SECTION B: #18B HEARING AIDS - BASE 4	No DE SA

6/4/2019

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

No

Is a referral required for Hearing Aids?

No

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

Does your plan include MA Uniformity

Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for

No

the Chronically Ill?

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

Does your VBID/MA Uniformity

No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

1

Benefits contain? (1-15)

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

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply?

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Other 1

: Other 2

Other 1 Description:

Oncology patients with active chep

infusion.

Other 2 Description:

Acute Stroke

Does the enrollee need to have all diseases

selected to qualify?

No

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

No

notes.

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

, INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

Yes

deductible?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits that are exempt from the plan-level

deductible:

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:



Benefit eligibility will be based on medical recommendation, and the following conditions: Post Inpatient stay with transition of care to patient's home, with Heart Failure (CHF), any class, Chronic Obstructive Pulmonary Disease (COPD), and Acute Stroke, Oncology Members with active chemo by infusion inpatient stay IP or Infusion Center.

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: In-Home Support Services*

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

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: 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 13: PACKAGE #1

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

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

BASE 15: PACKAGE #1

In-Home Support Services Notes:*

Benefit consists in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (maximum of four (4) hours per day for a maximum of 12 days in the calendar year).

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SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

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

Is there an In-Network Maximum Enrollee Out-

Yes

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3400.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Yes

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Actuarially Equivalent Standard : Standard/Preferred Retail Cost-Sharing

: In-Network Medicare-covered benefits

Describe the components of your network



(select all that apply):

: Out-of-Network Pharmacy

: Standard Mail Order Cost-Sharing

: Long Term Care Pharmacy

Sponsor attests that it will comply with 42 CFR 423.154.

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Yes

Does plan utilize ceiling pricing?

No

Are there quantity limits on certain prescription

Yes

drugs?

Is prior authorization required for certain prescription drugs?

Yes.

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

No

Do any drugs in your formulary require a step

Yes

therapy plan?

Yes

Do you pay for Over-the-Counter medications (OTCs) under the Utilization Management Program?

OTC Medication Attestation statement

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

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OSDE

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

Yes

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

6

What is your Formulary Exception Tier?

Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?

No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Cost Share Tiers



Initial Coverage Limit (ICL) is reached?

SECTION RX: TIER #1 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Preferred Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

that apply for this Tier:

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Long Term Care Pharmacy - one month supply

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SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Yes

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

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

No

supply for the first fill? SECTION RX: TIER #1 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-**ICL**

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing one month supply:



\$38.00 Indicate Copayment amount for Standard Retail

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$28,00

Cost-Sharing three month supply:

SECTION RX: TIER #1 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$28.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$19.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term \$14.00

Care Pharmacy one month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

\$0.63 Daily Standard Retail Copayment \$0.47 Daily Preferred Retail Copayment \$0.45 Daily Copayment for Long Term Care

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Tier Drug type(s) (select all that apply):

Part D Drugs Only Tier Includes:

Copayment Indicate the type of cost sharing structure:

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional): Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month sup

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your

90



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three month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

Νo

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$40.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$15.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$30.00

Cost-Sharing three month supply:

SECTION RX: TIER #2 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$30.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$20.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$15.00

Care Pharmacy one month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-IC

Daily Standard Retail Copayment Daily Preferred Retail Copayment

\$0.50

\$0.67

Daily Copayment for Long Term Care

\$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST SHARE STRUCTURE - PRE-IC

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Drug type(s) (select all that apply):

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL



Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier: : Standard Retail/Preferred Retail Cost-Sharing - one month supply

: Standard Retail/Preferred Retail Cost-Sharing - three month supply

: Out-of-Network Pharmacy - one month supply

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

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Tier (Optional):
Select all Long Term Care Pharmacy
Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30 Retail/Preferred Retail Cost-Sharing in your one

month supply:
Enter number of days for Standard
Retail/Preferred Retail Cost-Sharing in your

three month supply:

Tier:

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

Yes

90

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

Νo

SECTION RX: TIER #3 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order 90 Cost-Sharing in your three month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network
Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL
Indicate Copayment amount for Standard Retail \$47.00
Cost-Sharing one month supply:
Indicate Copayment amount for Standard Retail \$94.00
Cost-Sharing three month supply:
Indicate Copayment amount for Preferred Retail \$42.00
Cost-Sharing one month supply:

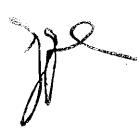
Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing three month supply:

SECTION RX: TIER #3 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail
Order Cost-Sharing three month supply:

\$84.00



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SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-I	SECTION RX	: TIER #3 - OON	AND LTC COPAYMENT	AND COINSURANCE - PRE-IC
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Indicate Copayment amount for Out-of-Network

\$47.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$42.00

Care Pharmacy one month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment

\$1.57

Daily Preferred Retail Copayment

\$1.40

Daily Copayment for Long Term Care

\$1.35

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Non-Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

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

Yes

Yes

90

SECTION RX: TIER #4 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order Cost-Sharing in your three month supply:

M

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SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing three month supply:

SECTION RX: TIER #4 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail

\$190.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$95.00

Care Pharmacy one month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-LÇL

Daily Standard Retail Copayment
Daily Preferred Retail Copayment

Daily Copayment for Long Term Care

\$3.17 \$3.06

\$3.33

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

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

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this

: Standard Mail Order Cost-Sharing - three month supply



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Tier (Optional):

Select all Long Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your

three month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Yes

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

Yes

supply for the first fill?

SECTION RX: TIER #5 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

90

Cost-Sharing in your three month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

Pharmacy one month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE -

ICL

Avg Expected Coins Dollar Amt Standard

\$15.00

Retail Cost-Sharing (1 month supply) (\$):

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing one month supply:

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing three month supply:

\$15.00

Avg Expected Coins Dollar Amt Preferred Retail Cost-Sharing (1 month supply) (\$):

\$12.00

Retail Cost-Sharing (1 month supply) (5): Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing one month supply:

2570

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing three month supply:

SECTION RX: TIER #5 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail Order Cost-Sharing three month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

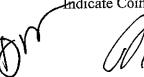
Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy one month supply:

25%

Indicate Coinsurance percentage for Long Term



Care Pharmacy one month supply:

SECTION RX: TIER #6 - TIER TYPE AND COST SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Tier Includes:

Part D Drugs Only

Indicate the type of cost sharing structure:

Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Tier:

Select all Standard Mail Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long Term Care Pharmacy

Location/supply amount(s) that apply for this

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your one

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your

three month supply:

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

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

supply for the first fill?

90

30

Yes

No

SECTION RX: TIER #6 - MAIL ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail Order

Cost-Sharing in your three month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

90

Enter number of days for Out-of-Network

Pharmacy in your one month supply:

Enter number of days for Long Term Care

31

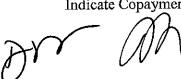
Pharmacy one month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-**ICL**

Indicate Copayment amount for Standard Retail

\$6.00

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Cost-Sharing one month supply:

Indicate Copayment amount for Standard Retail \$12.00

Cost-Sharing three month supply:

Indicate Copayment amount for Preferred Retail \$1.00

Cost-Sharing one month supply:

Indicate Copayment amount for Preferred Retail \$2.00

Cost-Sharing three month supply:

SECTION RX: TIER #6 - MAIL ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail \$2.00

Order Cost-Sharing three month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$6.00

Pharmacy one month supply:

Indicate Copayment Amount for Long Term

\$1.00

Care Pharmacy one month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.20

Daily Preferred Retail Copayment \$0.03

Daily Copayment for Long Term Care \$0.03

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP 2

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Preferred Brand

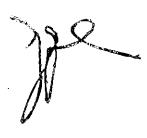
Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP

Select drug type(s) in this Tier (select all that : Brand

apply):





Tier Includes: Part D Drugs Only

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP. 4

Select drug type(s) in this Tier (select all that : Brand

apply):

Tier Includes: Part D Drugs Only

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Specialty Tier

Select the type of drug benefit: Actuarially Equivalent Standard

Tier ID - OOP 5

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier ID - OOP 6

Select drug type(s) in this Tier (select all that : Generic

apply): : Brand

Tier Includes: Part D Drugs Only



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