Appendix C-4

Bid Reports 2020

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 024
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Go To Additional Reports for H5774 - 024: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$45.00

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

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1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: [1]	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: [1]	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: [1]	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Worldwide Emergency Coverage: 1	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
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:	5
Select Routine Care periodicity:	Every year
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	No

7k Opioid Treatment Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
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
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

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10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 10% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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%

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

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11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
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?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
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:	75.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	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.

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13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
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

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

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14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	4
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: 1	$0.00
Indicate Maximum Copayment amount for Health Education: 1	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
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.
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.
Counseling Services Notes:	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.
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

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
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 Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	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 Medicare-covered Preventive Services?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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 (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
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 Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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
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
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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 Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
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

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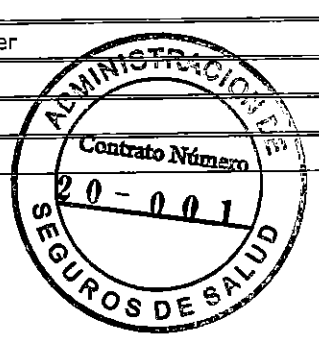
16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
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
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Non-routine Services: 1	$0.00
Indicate Maximum Copayment amount for Non-routine Services: 1	$0.00
Indicate Minimum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Maximum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Minimum Copayment amount for Restorative Services: 1	$0.00
Indicate Maximum Copayment amount for Restorative Services: 1	$0.00
Indicate Minimum Copayment amount for Endodontics: 1	$0.00
Indicate Maximum Copayment amount for Endodontics: 1	$0.00
Indicate Minimum Copayment amount for Periodontics: 1	$0.00
Indicate Maximum Copayment amount for Periodontics: 1	$0.00
Indicate Minimum Copayment amount for Extractions: 1	$0.00
Indicate Maximum Copayment amount for Extractions: 1	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
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 / 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.

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1



17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Select the Routine Eye Exams periodicity:	Every year
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service 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 there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment-amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	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.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
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:	850.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
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
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
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
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
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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
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:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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Bid Reports 2020

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 024
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Go To Additional Reports for H5774 - 024:

BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Go to another Bid for H5774:

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
Deductible	435.00	Pre-ICL Cost Shares	See below
Initial Coverage Limit	4020.00	Enrollee Out-of-Pocket Cost Threshold	$4,020.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable	Quantity Limits	Yes
Prior Authorization Required	Yes	Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes	OTC Medication Attestation statement: Per the CY 2009 Call Letter, 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.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes	Pharmacy Network Components	Standard/Preferred Retail Cost-Sharing; Out-of-Network Pharmacy; Standard

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
			Mail Order Cost-Sharing; Long Term Care Pharmacy
Utilizes floor pricing	Yes	Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No	Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.	Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.60 for generic or a preferred multi-source drug and $8.95 for all other drugs, or 5%	Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes

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Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.10
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Preferred Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.27
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$16.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30

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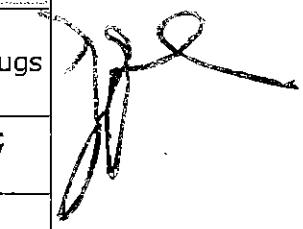
Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.10
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

Above Threshold						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only



Bid Reports 2020

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 025
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Ultra (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 3 - Renewal Plan Successfully Uploaded (06/03/19)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Go To Additional Reports for H5774 - 025: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	No

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Tiered Cost Sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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

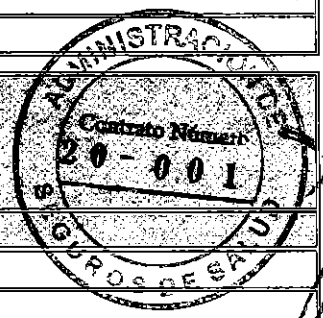
1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.



4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage: [1]	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage: [1]	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
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:	5
Select Routine Care periodicity:	Every year
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
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

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	No

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7k Opioid Treatment Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
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
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit: -	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available by automobile through a contracted provider.

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11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 10% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
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?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

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13b OTC Items Service Category Description Benefit Description	
Question	**Response**
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:	75.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	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.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**

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13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
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

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	4
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: [1]	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: [1]	$0.00
Indicate Minimum Copayment amount for Counseling Services: [1]	$0.00
Indicate Maximum Copayment amount for Counseling Services: [1]	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: [1]	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: [1]	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
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.
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.
Counseling Services Notes:	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.
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

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	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 Medicare-covered Preventive Services?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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 (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
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 Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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
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
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Dental X-Rays: [1]	$0.00
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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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 Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Non-routine Services: 1	$0.00
Indicate Maximum Copayment amount for Non-routine Services: 1	$0.00
Indicate Minimum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Maximum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Minimum Copayment amount for Restorative Services: 1	$0.00
Indicate Maximum Copayment amount for Restorative Services: 1	$0.00
Indicate Minimum Copayment amount for Endodontics: 1	$0.00
Indicate Maximum Copayment amount for Endodontics: 1	$0.00
Indicate Minimum Copayment amount for Periodontics: 1	$0.00
Indicate Maximum Copayment amount for Periodontics: 1	$0.00
Indicate Minimum Copayment amount for Extractions: 1	$0.00
Indicate Maximum Copayment amount for Extractions: 1	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
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 / 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.

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Select the Routine Eye Exams periodicity:	Every year
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service 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 there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	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.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
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
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
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
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
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
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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
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:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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Bid Reports 2020

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 025
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Ultra (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Go To Additional Reports for H5774 - 025:

BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Go to another Bid for H5774:

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
Deductible	435.00	Pre-ICL Cost Shares	See below
Initial Coverage Limit	4020.00	Enrollee Out-of-Pocket Cost Threshold	$4,020.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable	Quantity Limits	Yes
Prior Authorization Required	Yes	Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes	OTC Medication Attestation statement: Per the CY 2009 Call Letter, 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.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes	Pharmacy Network Components	Standard/Preferred Retail Cost-Sharing; Out-of-Network Pharmacy; Standard

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
			Mail Order Cost-Sharing; Long Term Care Pharmacy
Utilizes floor pricing	Yes	Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No	Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.	Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.60 for generic or a preferred multi-source drug and $8.95 for all other drugs, or 5%	Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes

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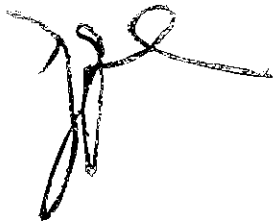
Pre-Initial Coverage Limit						
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.03
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$1.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Preferred Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$2.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.20
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$12.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30



Pre-Initial Coverage Limit						
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$2.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.03
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$1.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

Above Threshold						
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only

Bid Reports 2020

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 026
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero-dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Go To Additional Reports for H5774 - 026: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$100.00

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
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
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage: [1]	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage: [1]	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

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5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
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:	5
Select Routine Care periodicity:	Every year
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes
Notes:	$0 copay for services rendered in SALUS facil $2 copay for Medicare covered services.

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No
Notes:	

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	No

7k Opioid Treatment Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Is authorization required?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services: [1]	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services: [1]	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	No

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11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	20%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 20% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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:	20%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	20%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

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11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Notes:	20% 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.20% coinsurance for medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	No

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
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

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13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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.

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14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	No
Is a referral required?	No

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	4
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for 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

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: 1	$0.00
Indicate Maximum Copayment amount for Health Education: 1	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
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.
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.

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Counseling Services Notes:	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.

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	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 Medicare-covered Preventive Services?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes

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15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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
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 (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
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 Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
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 Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	600.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
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
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Non-routine Services: 1	$0.00
Indicate Maximum Copayment amount for Non-routine Services: 1	$0.00
Indicate Minimum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Maximum Copayment amount for Diagnostic Services: 1	$0.00

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Restorative Services: 1	$0.00
Indicate Maximum Copayment amount for Restorative Services: 1	$0.00
Indicate Minimum Copayment amount for Endodontics: 1	$0.00
Indicate Maximum Copayment amount for Endodontics: 1	$0.00
Indicate Minimum Copayment amount for Periodontics: 1	$0.00
Indicate Maximum Copayment amount for Periodontics: 1	$0.00
Indicate Minimum Copayment amount for Extractions: 1	$0.00
Indicate Maximum Copayment amount for Extractions: 1	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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, 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.

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Enter name of Other Service:	Eyewear eye exam

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service 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 there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	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.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
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:	100.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
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
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams
Select type of benefit for Routine Hearing Exams:	Mandatory

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
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
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: [1]	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	No

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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Bid Reports 2020

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 026
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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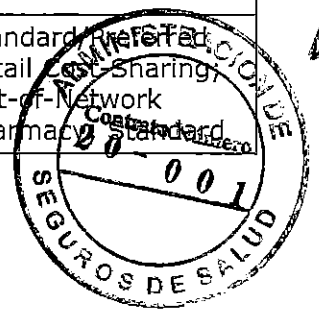
Go To Additional Reports for H5774 - 026:

BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Go to another Bid for H5774:

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
Deductible	435.00	Pre-ICL Cost Shares	See below
Initial Coverage Limit	4020.00	Enrollee Out-of-Pocket Cost Threshold	$4,020.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable	Quantity Limits	Yes
Prior Authorization Required	Yes	Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes	OTC Medication Attestation statement: Per the CY 2009 Call Letter, 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.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes	Pharmacy Network Components	Standard Retail Retail Cost Sharing Out-of-Network Pharmacy Standard



Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
			Mail Order Cost-Sharing; Long Term Care Pharmacy
Utilizes floor pricing	Yes	Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No	Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.	Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.60 for generic or a preferred multi-source drug and $8.95 for all other drugs, or 5%	Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes

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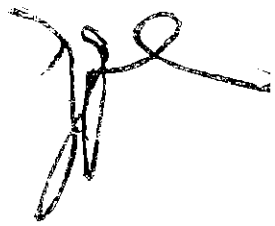
Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.50
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$15.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Preferred Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$30.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.67
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$20.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$40.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30



Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$20.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$30.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.48
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$15.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

Above Threshold						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only

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Bid Reports 2020

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 028
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Go To Additional Reports for H5774 - 028: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$80.00

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage: [1]	$0.00

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4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Worldwide Emergency Coverage: 1	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
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:	5
Select Routine Care periodicity:	Every year
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	No

7k Opioid Treatment Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	

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9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
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
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

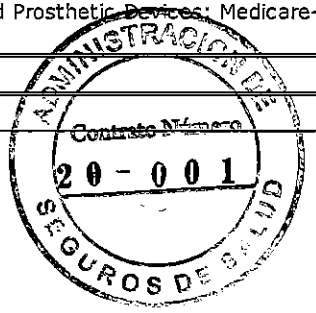
10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	20
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 10% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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%



11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
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?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
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:	40.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	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.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
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

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
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.

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	No
Is a referral required?	No

14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	4
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for 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

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14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: 1	$0.00
Indicate Maximum Copayment amount for Health Education: 1	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
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.

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
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.
Counseling Services Notes:	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.
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

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	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 Medicare-covered Preventive Services?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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
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 (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
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 Treatment:	1

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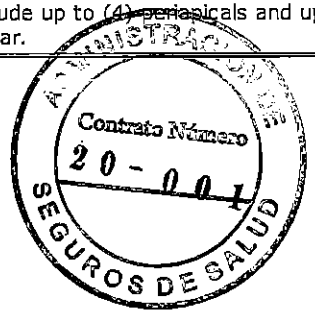
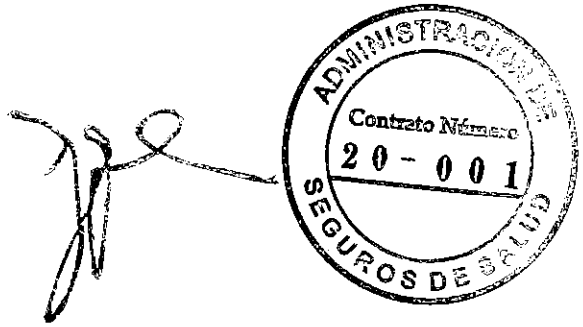
16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select the Fluoride Treatment periodicity:	Every six months
Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit 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
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
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
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.



16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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 Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
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 Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Non-routine Services: 1	$0.00
Indicate Maximum Copayment amount for Non-routine Services: 1	$0.00
Indicate Minimum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Maximum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Minimum Copayment amount for Restorative Services: 1	$0.00
Indicate Maximum Copayment amount for Restorative Services: 1	$0.00
Indicate Minimum Copayment amount for Endodontics: 1	$0.00
Indicate Maximum Copayment amount for Endodontics: 1	$0.00
Indicate Minimum Copayment amount for Periodontics: 1	$0.00
Indicate Maximum Copayment amount for Periodontics: 1	$0.00
Indicate Minimum Copayment amount for Extractions: 1	$0.00
Indicate Maximum Copayment amount for Extractions: 1	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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, 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.

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service 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 there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	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.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?-	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
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
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
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
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
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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Bid Reports 2020

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 028
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 3 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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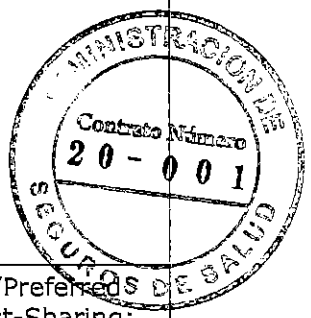
Go To Additional Reports for H5774 - 028:

BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Go to another Bid for H5774:

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
Deductible	435.00	Pre-ICL Cost Shares	See below
Initial Coverage Limit	4020.00	Enrollee Out-of-Pocket Cost Threshold	$4,020.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable	Quantity Limits	Yes
Prior Authorization Required	Yes	Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes	OTC Medication Attestation statement: Per the CY 2009 Call Letter, 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.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes	Pharmacy Network Components	Standard/Preferred Retail Cost-Sharing; Out-of-Network Pharmacy; Standard



Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
			Mail Order Cost-Sharing; Long Term Care Pharmacy
Utilizes floor pricing	Yes	Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No	Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.	Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.60 for generic or a preferred multi-source drug and $8.95 for all other drugs, or 5%	Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes

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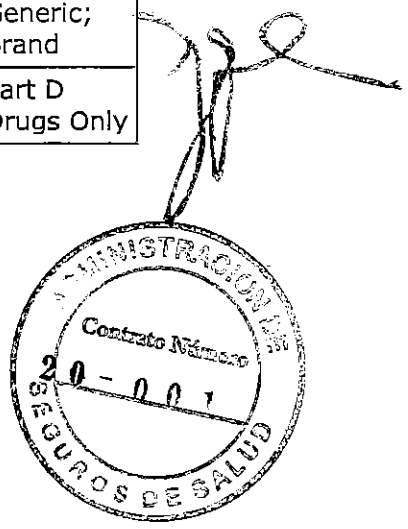
Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.10
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Preferred Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.27
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$16.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.10
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

Above Threshold						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only



Bid Reports 2020

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 032
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 2 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

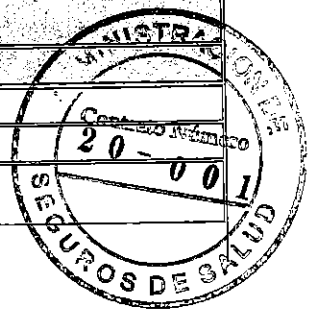
Go To Additional Reports for H5774 - 032: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Plan Level Data.	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$10.00

Tiered Cost sharing for Part B Services	
Question	**Response**
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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No



1b Inpatient Hospital Psychiatric Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4a Emergency Care/Post-Stabilization Care Service Category Description Benefit Description	
Question	**Response**

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
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.

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage: 1	$0.00

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Worldwide Emergency Coverage: 1	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage: 1	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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7a Primary Care Physician Services Service Category Description Benefit Description	
Question	**Response**
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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
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:	5
Select Routine Care periodicity:	Every year
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?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00

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7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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7i Physical Therapy and Speech-language Pathology Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	No

7k Opioid Treatment Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Opioid Treatment Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc): 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

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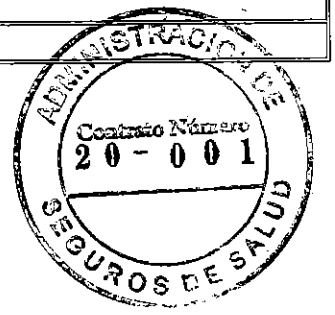
9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services: 1	$0.00
Indicate Minimum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Observation Services: 1	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No
Notes:	

9b Ambulatory Surgical Center (ASC) Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No
Notes:	

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
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
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No



10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
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
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services: 1	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	18
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

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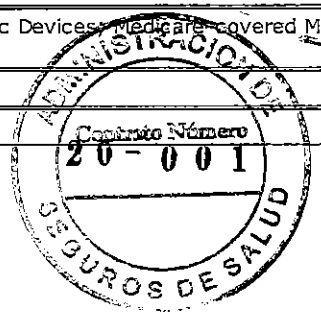
10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

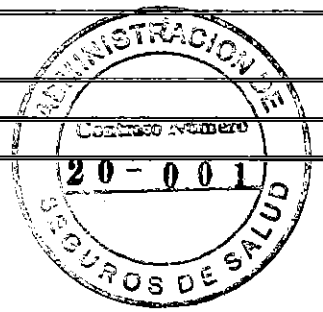
11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 10% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
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%



11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
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
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No



12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
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?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

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13b OTC Items Service Category Description Benefit Description	
Question	**Response**
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:	250.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	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 Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**

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13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
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

13d Other 1 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Extended Care Package (La Ñapa)
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Services?	No
Notes:	'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.

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13e Other 2	
Service Category Description	
Benefit Description	
Question	Response

13f Other 3	
Service Category Description	
Benefit Description	
Question	Response

13g Dual Eligible SNPs with Highly Integrated Services	
Service Category Description	
Benefit Description	
Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill	
Service Category Description	
Benefit Description	
Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services	
Service Category Description	
Benefit Description	
Question	Response
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

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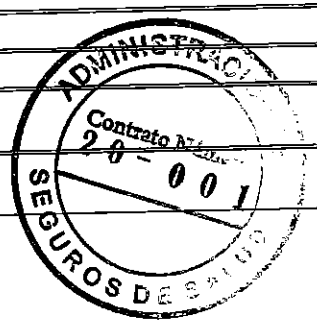
14b Annual Physical Exam Service Category Description Benefit Description	
Question	**Response**
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	4
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for 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
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No



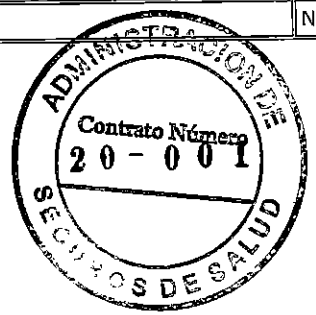
§14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: 1	$0.00
Indicate Maximum Copayment amount for Health Education: 1	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
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.
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.

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Counseling Services Notes:	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.
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

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
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
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diabetes Self-Management Training: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit: 1	$0.00
Indicate Minimum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Indicate Maximum Copayment amount for Other Medicare-covered Preventive Services: 1	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	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 Medicare-covered Preventive Services?	No
Is a referral required for any Services?	No



15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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
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 (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
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 Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months

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16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
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
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
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
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.

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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 Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
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 Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
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
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Non-routine Services: 1	$0.00
Indicate Maximum Copayment amount for Non-routine Services: 1	$0.00
Indicate Minimum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Maximum Copayment amount for Diagnostic Services: 1	$0.00
Indicate Minimum Copayment amount for Restorative Services: 1	$0.00
Indicate Maximum Copayment amount for Restorative Services: 1	$0.00
Indicate Minimum Copayment amount for Endodontics: 1	$0.00
Indicate Maximum Copayment amount for Endodontics: 1	$0.00
Indicate Minimum Copayment amount for Periodontics: 1	$0.00
Indicate Maximum Copayment amount for Periodontics: 1	$0.00
Indicate Minimum Copayment amount for Extractions: 1	$0.00
Indicate Maximum Copayment amount for Extractions: 1	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
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, 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.

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Indicate quantity for Other Service:	1
Select the Other Service 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 there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	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.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
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?	Yes

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
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
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:	200.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
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
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
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
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
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
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
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

[1] This row is populated in the PBP Benefit report with a $0 copay because the plan has indicated no copayment and no coinsurance in their PBP Data entry.

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Bid Reports 2020

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 032
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 2 - Renewal-Plan Successfully Uploaded (06/03/19)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00020555
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Go To Additional Reports for H5774 - 032:

BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report | Benefits Summary Report

Go to another Bid for H5774:

Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
Deductible	435.00	Pre-ICL Cost Shares	See below
Initial Coverage Limit	4020.00	Enrollee Out-of-Pocket Cost Threshold	$4,020.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable	Quantity Limits	Yes
Prior Authorization Required	Yes	Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes	OTC Medication Attestation statement: Per the CY 2009 Call Letter, 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.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes	Pharmacy Network Components	Standard/Preferred Retail Cost-Sharing; Out-of-Network Pharmacy; Standard

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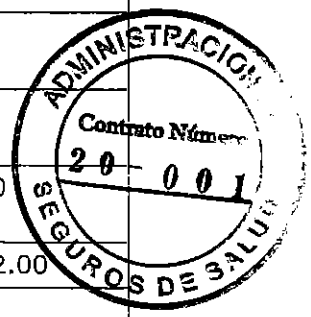
Part D Benefit Data			
Benefit	**Plan Data**	**Benefit**	**Plan Data**
			Mail Order Cost-Sharing; Long Term Care Pharmacy
Utilizes floor pricing	Yes	Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No	Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.	Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.60 for generic or a preferred multi-source drug and $8.95 for all other drugs, or 5%	Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.03
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$1.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Preferred Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$2.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.20
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, Average Expected 1 Month Coinsur					$15.00	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$12.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30



Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$2.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.03
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$1.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

Above Threshold						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only