MEDICARE PLATINO 2021

APPENDIX C (1) (21)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFIT

Appendix C-1

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 024, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	05/31/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/31/2020 05:40:29 PM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 05:13:10 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:15:18 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

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

SECTION A: SECTION A-1

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

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

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	024
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for this plan:	309161
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777

SECTION A: SECTION A-4

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

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

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Does this plan's Additional Days cost sharing	No

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

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

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

Is there an enrollee Copayment?	No

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

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

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

Does the plan provide Worldwide 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

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

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

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

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	24
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%

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

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

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

Is authorization required?	Yes
Notes:	5% 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.5% coinsurance for

	medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	No
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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

SECTION B: #13A ACUPUNCTURE - BASE 3

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

SECTION B: #13B OTC ITEMS - BASE 1

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.

SECTION B: #13B OTC ITEMS - BASE 2

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

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SECTION B: #13B OTC ITEMS - BASE 3

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

	The Blood Pressure Monitor is covered up to one (1) every 5 years.
SECTION B: #13C MEAL BENEFIT - BASE 1	
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No
SECTION B: #13E OTHER 2 - BASE 1	
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13E OTHER 2 - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No
SECTION B: #13E OTHER 2 - BASE 3	
Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.
SECTION B: #13F OTHER 3 - BASE 1	
Enter name of Service (Optional):	Covid-19 Delivery Charge Payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #13F OTHER 3 - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
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

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Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an

	emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

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

Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

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

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

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

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

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

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

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

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

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

Glaucoma Screening?	
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

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

Is a referral required for any Services?	No

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

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

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

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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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
Indicate quantity for Other Service:	1

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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
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	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.
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames : Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 2	
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan 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

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1

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

SECTION B: #18A HEARING EXAMS - BASE 2

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

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	: Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

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SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

	: Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	23925

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

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

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

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

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

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

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

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Open Heart Surgery

Other 4 Description:	Hip Surgery
Other 5 Description:	knee surgery
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

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

Select type of benefit for In-Home Support	Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

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

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

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

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

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

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional	: 13i-O: Non-Primarily Health Related Benefits

benefits offered in this package:	for the Chronically Ill (Other)

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	After member's clinical identification process they will be sent a card with allowance for the purchase of groceries, groceries delivery charges and thorough house cleaning performed by a contracted professional. Funds will be deposited once every quarter of the year while the member remains active in the plan.

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

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2

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

Enter name of Service:	Groceries and Cleaning Services Card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	225.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	Allowance is not cumulative and is restricted to the following 2 combined benefits:

	Payment for thorough house cleaning performed by a contracted professional Purchase of food and groceries delivery charges Benefit will not include: Beer, wine, liquor, cigarettes, or tobacco Vitamins, medicines, and supplements Any nonfood items such as: Pet foods Cleaning supplies, paper products, and other household supplies. Hygiene items, cosmetics

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

Enter name of Service:	Transportation to Non-Health Related Destinations
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

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

Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

SECTION B: #19C VBID HOSPICE- BASE 1

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

SECTION B: #19C VBID HOSPICE- BASE 2

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

SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step	Yes

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Therapy Protocol submitted for review and approval by CMS?	

SECTION RX: MEDICARE RX GENERAL 3

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

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

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

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-	90

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$19.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$38.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$14.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$19.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$14.00

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

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

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$30.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$30.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$20.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$15.00

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

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

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

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

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

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply

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

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

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

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

Pharmacy

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Coinsurance percentage for Standard	25%

Retail Cost-Sharing 1-month supply:	
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$8.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$16.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$3.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$6.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$6.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$8.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$3.00

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

Daily Standard Retail Copayment	$0.27
Daily Preferred Retail Copayment	$0.10
Daily Copayment for Long-Term Care Pharmacy	$0.10

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	1

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 025, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	05/31/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/31/2020 05:40:55 PM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 05:13:34 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:15:37 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

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

SECTION A: SECTION A-1

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

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

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	025
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for this plan:	83082
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777

SECTION A: SECTION A-4

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

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

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Does this plan's Additional Days cost sharing	No

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

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

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

Is there an enrollee Copayment?	No

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

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

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

Does the plan provide Worldwide 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

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

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

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

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

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Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	24
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in a automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%

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

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

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

Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices.

	0% coinsurance for medical supplies preferred brands and manufacturers. 5% coinsurance for medical supplies non preferred brands and manufacturers.

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes

SECTION B: #13A ACUPUNCTURE - BASE 2

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

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

SECTION B: #13A ACUPUNCTURE - BASE 3

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

SECTION B: #13B OTC ITEMS - BASE 1

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.

SECTION B: #13B OTC ITEMS - BASE 2

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

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SECTION B: #13B OTC ITEMS - BASE 3

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

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

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	Covid-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13E OTHER 2 - BASE 2

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

SECTION B: #13E OTHER 2 - BASE 3

Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13F OTHER 3 - BASE 2

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

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

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
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

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Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20

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

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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an

	emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

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

Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

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

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

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

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

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

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

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

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

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

Glaucoma Screening?	
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

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

Is a referral required for any Services?	No

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

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

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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

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Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every two years
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

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
Indicate quantity for Other Service:	1

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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
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	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.
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames : Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 2	
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes

Indicate Combined Maximum Plan Benefit Coverage amount:	1000.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

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

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1

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

SECTION B: #18A HEARING EXAMS - BASE 2

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

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	: Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

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SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

	: Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	9496

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

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

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

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

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

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

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

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Open Heart Surgery

Other 4 Description:	Hip Surgery
Other 5 Description:	Knee Surgery
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level deductible?	Yes
Select all the Non-Medicare-covered additional benefits that are exempt from the plan-level deductible:	: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

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

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

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

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

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

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

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

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	After member's clinical identification process they will be sent a card with allowance for the purchase of groceries, groceries delivery charges and thorough house cleaning performed by a contracted professional. Funds will be deposited once every quarter of the year while the member remains active in the plan.

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

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2

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

Enter name of Service:	Groceries and Cleaning Services Card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	225.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

BENEFIT - BASE 3: PACKAGE #2

Notes:	Allowance is not cumulative and is restricted to the following 2 combined benefits: Payment for thorough house cleaning performed by a contracted professional Purchase of food and groceries delivery charges Benefit will not include: Beer, wine, liquor, cigarettes, or tobacco Vitamins, medicines, and supplements Any nonfood items such as: Pet foods Cleaning supplies, paper products, and other household supplies. Hygiene items, cosmetics

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

Enter name of Service:	Transportation to Non-Health Related Destinations
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

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

Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

SECTION B: #19C VBID HOSPICE- BASE 1

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

SECTION B: #19C VBID HOSPICE- BASE 2

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

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
SECTION B: #19C VBID HOSPICE- BASE 3	
Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
SECTION B: #19C VBID HOSPICE- BASE 4	
Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.
SECTION C: V/T - GENERAL - US	
Do you offer a US Visitor/Travel Program?	No
SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)	
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)	
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary

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Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and

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	distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes

SECTION RX: MEDICARE RX GENERAL 3

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

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

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

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$19.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$38.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$14.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$19.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$14.00

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

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

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$30.00

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

Indicate Copayment amount for Standard Mail-	$30.00

Order Cost-Sharing 3-month supply:	

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$20.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$15.00

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

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

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order	90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

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

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

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this	: Standard Mail Order Cost-Sharing - three month supply

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

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

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

Daily Standard Retail Copayment	$3.33
Daily Preferred Retail Copayment	$3.17

Daily Copayment for Long-Term Care Pharmacy	$3.06

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Coinsurance percentage for Standard Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this	Yes

tier available with an extended day supply?	
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$6.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$12.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$2.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$4.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$4.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$6.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$2.00

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

Daily Standard Retail Copayment	$0.20
Daily Preferred Retail Copayment	$0.07
Daily Copayment for Long-Term Care Pharmacy	$0.06

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only

Tier ID - OOP	1

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No

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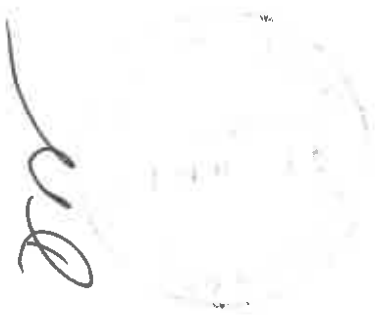

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 026, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	06/01/2020 09:38:50 AM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 05:13:57 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:15:55 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

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

SECTION A: SECTION A-1

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

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

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	026
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for this plan:	29074
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777

SECTION A: SECTION A-4

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

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

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	Yes
Select the benefits that have tiered cost sharing:	: Medicare-covered
Select the Medicare-covered benefits that have tiered cost sharing:	: 7f: Podiatry Services

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

Is there an enrollee Coinsurance?	No

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

Does this plan's Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?	No

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

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

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

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

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

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

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

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

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

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

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

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No

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

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

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

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

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

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

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

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

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

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

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

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

Is there an enrollee Copayment?	No

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

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

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

Does the plan provide Worldwide 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

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

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

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

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

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 : Routine Foot Care
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:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes
Notes:	$0 copay for services rendered in SALUS facility. $2 copay for Medicare covered services.

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

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

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

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

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

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

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

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

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

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

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

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

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

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

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

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

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

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

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #9B ASC SERVICES - BASE 1

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

SECTION B: #9B ASC SERVICES - BASE 2

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

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

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

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

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

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

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

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

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

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

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

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory

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Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	10
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 10% coinsurance for non preferred brands and manufacturers.

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

Is there a service-specific Maximum Enrollee	No

Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%

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

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

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

Is authorization required?	Yes
Notes:	10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and non-surgically implanted prosthetic devices. 0% coinsurance for medical supplies preferred brands and manufacturers.10% coinsurance for medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.

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

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

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

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	No

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13E OTHER 2 - BASE 2

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

SECTION B: #13E OTHER 2 - BASE 3

Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage	10.00

amount:	
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13F OTHER 3 - BASE 2

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

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

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

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

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

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

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions

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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

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

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

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

Is there an enrollee Coinsurance?	No

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

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

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

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

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

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care

	instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

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

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

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

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

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

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

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

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

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

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

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

Is a referral required for any Services?	No

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

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

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

Is there an enrollee Copayment?	No
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?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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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SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan	No

Benefit Coverage amount?	
SECTION B: #16A PREVENTIVE DENTAL - BASE 3	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #16A PREVENTIVE DENTAL - BASE 4	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #16A PREVENTIVE DENTAL - BASE 5	
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1	
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	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
SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2	
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes

Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
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
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	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

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	cover under the Other eye exam, consultation and prescription for eyewear including refraction.
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	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
SECTION B: #17B EYEWEAR - BASE 2	
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan 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
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No

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SECTION B: #18A HEARING EXAMS - BASE 1

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
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

SECTION B: #18A HEARING EXAMS - BASE 2

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

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	No

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

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

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SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or	: Telephonic

more):	: In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	1185

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

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

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

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

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

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

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

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Open Heart Surgery
Other 4 Description:	Hip Surgery
Other 5 Description:	Knee Surgery
Does the enrollee need to have all diseases	No

selected to qualify?

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

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

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

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

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

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

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

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

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

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

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

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

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

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

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

Targeting Methodology - Please choose one or both:	: Chronic Condition(s)
Which disease states does this benefit apply? (Select all that apply):	: Other CMS-Approved Disease State
Expected Number of Enrollees to be Targeted:	1263
Expected Number of Enrollees to be engaged	1263

and receive Model benefits:

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

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

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

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

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

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

Notes:	Cash or Monetary Rebates

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

Enter name of Service (Optional):	Cash or Monetary Rebates
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	160.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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

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

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

Notes:	For each member, rebate will be of $160 every month with a maximum of up to $1,920 per member per year in the form of a debit card.

SECTION B: #19C VBID HOSPICE- BASE 1

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

SECTION B: #19C VBID HOSPICE- BASE 2

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

SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

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

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-	Voluntary

Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC

	drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes

SECTION RX: MEDICARE RX GENERAL 3

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

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

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

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$19.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$38.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$14.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$28.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$19.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$14.00

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

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

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard

Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail	$30.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$30.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$20.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$15.00

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

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

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month	No

supply for the first fill?

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

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

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

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy	: Out-of-Network Pharmacy - one month supply

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

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

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

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

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care	31

Pharmacy 1-month supply:

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

Indicate Coinsurance percentage for Standard Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

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

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

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

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard	90

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Retail/Preferred Retail Cost-Sharing in your 3-month supply:	
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

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

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

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

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

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

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$10.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$20.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$5.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$10.00

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

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$10.00

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

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$10.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$5.00

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

Daily Standard Retail Copayment	$0.33
Daily Preferred Retail Copayment	$0.17
Daily Copayment for Long-Term Care Pharmacy	$0.16

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

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

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

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	1

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

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

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

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

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

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

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

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

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

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 028, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	05/31/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/31/2020 05:34:59 PM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 05:14:44 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:16:32 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

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

SECTION A: SECTION A-1

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

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

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Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	028
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for this plan:	147646
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777

SECTION A: SECTION A-4

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

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

SECTION A: SECTION A-5

Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes

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

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

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

Does this plan's Additional Days cost sharing	No

vary by hospital(s) in which an enrollee obtains care?	

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

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Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide 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

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Psychiatric Services?	No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

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Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

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

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	20
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes
Notes:	5% 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.5% coinsurance for

	medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Dialysis Services?	No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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Is authorization required?	No
Is a referral required for Acupuncture?	No

SECTION B: #13A ACUPUNCTURE - BASE 3

Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

SECTION B: #13B OTC ITEMS - BASE 1

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.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	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.

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	The Blood Pressure Monitor is covered up to one (1) every 5 years

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13E OTHER 2 - BASE 3

Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13F OTHER 3 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?	No
Is a referral required for Other Defined 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.

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SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an

	emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered	No

Glaucoma Screening?	
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

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B? : Part B to Part D? : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

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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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
Indicate quantity for Other Service:	1

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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

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?	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.

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames : Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan 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

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Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: 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

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program

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	: In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	11180

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #1

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Open Heart Surgery
Other 4 Description:	Hip Surgery

Other 5 Description:	Knee Surgery
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for In-Home Support Services:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

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SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00

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Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step	Yes

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Therapy Protocol submitted for review and approval by CMS?	

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:	6
What is your Formulary Exception Tier?	4
Do you apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?	No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) cost-sharing structure for this plan:	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?	Cost Share Tiers

SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-	90

month supply:	
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$30.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$10.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$20.00

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$20.00

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$15.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$10.00

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.50
Daily Preferred Retail Copayment	$0.33
Daily Copayment for Long-Term Care Pharmacy	$0.32

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$20.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$15.00

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.67
Daily Preferred Retail Copayment	$0.50
Daily Copayment for Long-Term Care Pharmacy	$0.48

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$1.57
Daily Preferred Retail Copayment	$1.40
Daily Copayment for Long-Term Care Pharmacy	$1.35

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$3.33
Daily Preferred Retail Copayment	$3.17
Daily Copayment for Long-Term Care	$3.06

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #5 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard	25%

Retail Cost-Sharing 1-month supply:	
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$8.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$16.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$2.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$4.00

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SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$4.00

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$8.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$2.00

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.27
Daily Preferred Retail Copayment	$0.07
Daily Copayment for Long-Term Care Pharmacy	$0.06

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost Threshold?	Medicare-defined Post Threshold Cost Shares

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	1

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 032, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	06/01/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	06/01/2020 08:37:05 AM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 05:15:31 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:17:09 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

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Organization Legal Name:	TRIPLE S ADVANTAGE, INC.
Organization Marketing Name:	Triple S Advantage
Organization Web Site:	www.sssadvantage.com
Plan Name:	Platino Enlace (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	

Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	032
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2021 total projected member months for this plan:	6000
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number	(877)207-8777

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5	
Does this plan's Additional Days cost sharing	No

vary by hospital(s) in which an enrollee obtains care?	

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Hospital-Acute Services?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #2 SNF - BASE 2

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Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide 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

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Servicés 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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Psychiatric Services?	No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

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

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	18
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%

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SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes
Notes:	5% 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.5% coinsurance for

	medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	No
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

Is authorization required?	No
Is a referral required for Acupuncture?	No

SECTION B: #13A ACUPUNCTURE - BASE 3

Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

SECTION B: #13B OTC ITEMS - BASE 1

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:	350.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

SECTION B: #13B OTC ITEMS - BASE 3

Notes:	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

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13E OTHER 2 - BASE 3

Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13F OTHER 3 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
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

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Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative 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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?	No
Is a referral required for Other Defined 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.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an

	emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered	No

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Glaucoma Screening?	
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

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B? : Part B to Part D? : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.
SECTION B: #17A EYE EXAMS - BASE 1	
Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
Indicate quantity for Other Service:	1

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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
SECTION B: #17A EYE EXAMS - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
SECTION B: #17A EYE EXAMS - BASE 3	
Is authorization required?	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.
SECTION B: #17B EYEWEAR - BASE 1	
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames : Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
SECTION B: #17B EYEWEAR - BASE 2	
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
SECTION B: #17B EYEWEAR - BASE 3	
Is there a service-specific Maximum Plan 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

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?	No
Is a referral required for Eyewear?	No

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: 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

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit : Medicare Health Risk Assessment : Care Management Program

	: In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	363

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #1

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Open Heart Surgery
Other 4 Description:	Hip Surgery

Other 5 Description:	Knee Surgery
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

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SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for In-Home Support Services:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

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SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	Yes
Select the number of Combined Supplemental Benefit packages you are offering?	1

SECTION D: COMBINED BENEFITS #1

Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	: 10b2: Transportation Services - Any Health-related Location : 13b: Over-the-Counter (OTC) Items : 16b1: Non-routine Services : 16b2: Diagnostic Services : 16b3: Restorative Services : 16b4: Endodontics : 16b5: Periodontics : 16b6: Extractions : 16b7: Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services : 17b1: Contact Lenses : 17b2: Eyeglasses (lenses and frames) : 17b3: Eyeglass lenses : 17b4: Eyeglass frames : 17b5: Upgrades : 18b1: Hearing Aids (all types)
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	No
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	Yes

SECTION D: NOTES

Notes:	The Flex benefit allows the member to choose one of the following additional, supplemental benefits: 10b-Transportation: Additional 18 trips for a total of 36 trips. If member chooses another Flex benefit, the total trips will be 18. 13b-OTC: Additional $25 for a total of $375. If member chooses another Flex benefit, the total

	will be $350. 16b-Comp Dental: Additional $1,500 for a total $2,500. If member chooses another Flex benefit, the total will be $1,000. 17b-Eyewear: Additional $150 for a total of $350. If member chooses another Flex benefit, the total will be $200. 18b- Hearing Aids: Additional $1,500 for a total of $2,500. If member chooses another Flex benefit, the total will be $1,000.
SECTION RX: MEDICARE RX GENERAL 1	
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.
SECTION RX: MEDICARE RX GENERAL 2	
Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes
SECTION RX: MEDICARE RX GENERAL 3	
Indicate number of Tiers in your Part D benefit:	6

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What is your Formulary Exception Tier?	4
Do you apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?	No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) cost-sharing structure for this plan:	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?	Cost Share Tiers

SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended	No

day supply for this tier limited to a 1-month supply for the first fill?	

SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$19.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$38.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$14.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$28.00

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$28.00

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$19.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$14.00

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.63
Daily Preferred Retail Copayment	$0.47
Daily Copayment for Long-Term Care Pharmacy	$0.45

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$20.00
Indicate Copayment Amount for Long-Term	$15.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.67
Daily Preferred Retail Copayment	$0.50
Daily Copayment for Long-Term Care Pharmacy	$0.48

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care	31

Pharmacy 1-month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$1.57
Daily Preferred Retail Copayment	$1.40
Daily Copayment for Long-Term Care Pharmacy	$1.35

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

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SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$3.33
Daily Preferred Retail Copayment	$3.17
Daily Copayment for Long-Term Care Pharmacy	$3.06

SECTION RX: TIER #5 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard

Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #5 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order	90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$6.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$12.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$2.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$4.00

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$4.00

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$6.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$2.00

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.20
Daily Preferred Retail Copayment	$0.07
Daily Copayment for Long-Term Care Pharmacy	$0.06

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost Threshold?	Medicare-defined Post Threshold Cost Shares

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	1

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that	: Generic

apply):	
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 035, SEGMENT 0

Module:	PBP
Requested By:	rzwg

PLAN SYSTEM INFORMATION

Last entry Date:	05/31/2020
PBP Software Version:	2021.01
Plan Ready for Upload Timestamp:	05/31/2020 05:29:18 PM SA Western Standard Time
MA BPT Timestamp:	06/01/2020 09:20:31 PM SA Western Standard Time
PD BPT Timestamp:	06/01/2020 04:17:45 PM SA Western Standard Time
Last Upload File Creation Timestamp:	06/01/2020 09:29:30 PM SA Western Standard Time
Upload Status:	06/01/2020 #02500

PLAN STATUS

Section A Status	Plan Ready for Upload
Section B1 Status	Completed
Section B2 Status	Completed
Section B3 Status	Completed
Section B4 Status	Completed
Section B5 Status	Completed
Section B6 Status	Completed
Section B7 Status	Completed
Section B8 Status	Completed
Section B9 Status	Completed
Section B10 Status	Completed
Section B11 Status	Completed
Section B12 Status	Completed
Section B13 Status	Completed
Section B14 Status	Completed
Section B15 Status	Completed
Section B16 Status	Completed
Section B17 Status	Completed
Section B18 Status	Completed
Section B19 Status	Completed
Section C Status	Completed
Section D Status	Completed
Section Mrx Status	Completed

SECTION A: SECTION A-1

Organization Legal Name:	TRIPLE S ADVANTAGE, INC.
Organization Marketing Name:	Triple S Advantage
Organization Web Site:	www.sssadvantage.com
Plan Name:	Platino Alcance (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	

Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	

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	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	035
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2021 total projected member months for this plan:	32620
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(877)207-8777
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(877)207-8777
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number	(877)207-8777

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for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5	
Does this plan's Additional Days cost sharing	No

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vary by hospital(s) in which an enrollee obtains care?	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12	
What is your Inpatient Hospital-Acute benefit period?	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
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1	
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12	
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No
SECTION B: #2 SNF - BASE 1	
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #2 SNF - BASE 2	

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?	No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?	No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

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Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide 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

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Home Health Services?	No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

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Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	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

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?	No
Is a referral required for Psychiatric Services?	No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

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SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services : 7d: Physician Specialist Services : 7e1: Individual Sessions for Mental Health Specialty Services : 7h1: Individual Sessions for Psychiatric Services : 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	Yes
Is a referral required for Medicare-covered Outpatient Hospital Services?	No
Is a referral required for Medicare-covered Observation Services?	No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

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

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Medicare services?	Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	48
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	: Taxi : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Is authorization required?	Yes
Notes:	5% 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.5% coinsurance for

	medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2	
Is there an enrollee Copayment?	No
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 1	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #12 DIALYSIS SERVICES - BASE 2	
Is authorization required?	No
Is a referral required for Dialysis Services?	No
SECTION B: #13A ACUPUNCTURE - BASE 1	
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	: Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
SECTION B: #13A ACUPUNCTURE - BASE 2	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

Is authorization required?	No
Is a referral required for Acupuncture?	No

SECTION B: #13A ACUPUNCTURE - BASE 3

Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No

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SECTION B: #13B OTC ITEMS - BASE 3

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.

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13E OTHER 2 - BASE 3

Notes:	Benefit consists of a $50 allowance for the purchase of food after being diagnosed with Covid-19 during a public health emergency for Covid-19 with a stay at home order. Up to 2 allowances per year.

SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #13F OTHER 3 - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No

SECTION B: #13F OTHER 3 - BASE 3

Notes:	Benefit consists of a $10 allowance to pay for delivery charges. Benefit is limited to one time per month for affected enrollees during a public health emergency for COVID-19 with a stay at home order.

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive Services Attestation	: I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c1: Health Education : 14c2: Nutritional/Dietary Benefit : 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:	6
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

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Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative 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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?	No
Is a referral required for Other Defined 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.

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SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an

	emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered	No

Glaucoma Screening?	
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

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	: Part B to Part B? : Part B to Part D? : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Oral Exams : Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays
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

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Non-routine Services : Diagnostic Services : Restorative Services : Endodontics : Periodontics : Extractions : Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services

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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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 months, 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 dentures every 5 years / Implant/abutment supported removable denture for edentulous arch-maxillary. / Implant/abutment supported removable denture for edentulous arch-mandibular. / Partials and dentures on implants are mutually exclusive and cannot be replaced until after 5 years. / Oral Surgery: Extraction of erupted tooth, exposed root or impacted-1 per tooth per life, Incision and drainage of abscess soft tissue- 1 per quadrant every year, Biopsy-1 per lesion, Unspecified oral surgery procedure, by report.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?	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
Indicate quantity for Other Service:	1

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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

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?	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.

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Contact lenses : Eyeglasses (lenses and frames) : Eyeglass lenses : Eyeglass frames : Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan 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

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Indicate Combined Maximum Plan Benefit Coverage amount:	750.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
SECTION B: #17B EYEWEAR - BASE 4	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #17B EYEWEAR - BASE 5	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #17B EYEWEAR - BASE 6	
Is authorization required?	No
Is a referral required for Eyewear?	No
SECTION B: #18A HEARING EXAMS - BASE 1	
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
SECTION B: #18A HEARING EXAMS - BASE 2	
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #18A HEARING EXAMS - BASE 3	
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?	No
Is a referral required for Hearing Aids?	No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	: Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):	: Annual Wellness Visit

	: Medicare Health Risk Assessment : Care Management Program : In-home Assessments
WHP Mode of Engagement (choose one or more):	: Telephonic : In-Person : Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	: Electronic Health Records/Electronic Medical Records : Provider/Patient portals : Health Information Exchanges : Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	2718

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #1

Which disease states does this benefit apply? (Select all that apply):	: Chronic Obstructive Pulmonary Disease (COPD) : Congestive Heart Failure (CHF) : Other 1 : Other 2 : Other 3 : Other 4 : Other 5
Other 1 Description:	Oncology patients with active chemo by infusion
Other 2 Description:	Acute Stroke
Other 3 Description:	Hip Surgery

Other 4 Description:	Knee Surgery
Other 5 Description:	Open Heart Surgery
Does the enrollee need to have all diseases selected to qualify?	No
Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:	Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Members with active chemo by infusion inpatient stay (IP) or infusion - Patients discharged from open heart surgery or hip surgery or knee surgery with transition of care to patient's home

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	: 14c21: In-Home Support Services*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2: PACKAGE #1

Select type of benefit for In-Home Support Services:	Mandatory

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

In-Home Support Services Notes:*	Benefit consists of in home support for activities of daily living such as: Help with bathing and with dressing, Transferring or mobility help in the home, Light housekeeping (cleaning, laundry, dishes), Meal preparation, Help with medication reminders. This benefit provides for an in-home health aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 48 hours of care in a calendar year (four (4) hours per day for a maximum of 12 days in the calendar year).

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SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits for this package?	No
Select all the Non-Medicare-covered additional benefits offered in this package:	: 13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level deductible?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?	No
Is there a maximum benefit amount?	No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:	After member's clinical identification process they will be sent a card with allowance for the purchase of groceries, groceries delivery charges and thorough house cleaning performed by a contracted professional. Funds will be deposited once every quarter of the year while the member remains active in the plan.

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL, OTHER - TYPE: PACKAGE #2

Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	: Other 1 : Other 2

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:	Groceries and cleaning services card
Select type of benefit for Other 1:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	375.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 1 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 1 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:	Allowance is not cumulative and is restricted to the following 2 combined benefits:

	Payment for thorough house cleaning performed by a contracted professional Purchase of food and groceries delivery charges Benefit will not include: Beer, wine, liquor, cigarettes, or tobacco Vitamins, medicines, and supplements Any nonfood items such as: Pet foods Cleaning supplies, paper products, and other household supplies. Hygiene items, cosmetics

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 1: PACKAGE #2

Enter name of Service:	Transportation to Non-Health Related Destinations
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other 2 Services?	No

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 3: PACKAGE #2

Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes	In-Home Support Benefit -The benefit consists of qualified staff in-home support for activities of daily living such as: Help for bathing and dressing, transferring or assistance for mobility at home, light housekeeping (cleaning, laundry, cleaning dishes), meal preparation and help with medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?	No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?	No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits

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Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage Amount?	No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?	No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with uniform cost sharing?	No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Actuarially Equivalent Standard
Describe the components of your pharmacy network (select all that apply):	: Standard/Preferred Retail : Out-of-Network : Standard Mail-Order : Long-Term Care
Sponsor attests that it will comply with 42 CFR 423.154.	: Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?	Yes
Does plan utilize ceiling pricing?	No
Are there quantity limits on certain prescription drugs?	Yes
Is prior authorization required for certain prescription drugs?	Yes
Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?	No
Do any drugs in your formulary require a step therapy plan?	Yes
Do you pay for over-the-counter medications (OTCs) under the utilization management program?	Yes
OTC Medication Attestation statement	: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.
Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:	6
What is your Formulary Exception Tier?	4
Do you apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?	No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):	Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) cost-sharing structure for this plan:	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?	Cost Share Tiers

SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this	Yes

tier available with an extended day supply?	
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$19.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$38.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$14.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$28.00

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$28.00

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$19.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$14.00

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.63
Daily Preferred Retail Copayment	$0.47
Daily Copayment for Long-Term Care Pharmacy	$0.45

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)	: Standard Retail/Preferred Retail Cost-Sharing - one month supply

that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$20.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$40.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$15.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$30.00

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network	$20.00

Pharmacy 1-month supply:	
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$15.00

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.67
Daily Preferred Retail Copayment	$0.50
Daily Copayment for Long-Term Care Pharmacy	$0.48

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network	30

Pharmacy in your 1-month supply:	
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$47.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$94.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$42.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$84.00

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$47.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$42.00

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$1.57
Daily Preferred Retail Copayment	$1.40
Daily Copayment for Long-Term Care Pharmacy	$1.35

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this	: Long Term Care Pharmacy - one month supply

Tier:

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$100.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$200.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$95.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$190.00

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$190.00

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$100.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$95.00

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$3.33
Daily Preferred Retail Copayment	$3.17
Daily Copayment for Long-Term Care Pharmacy	$3.06

SECTION RX: TIER #5 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	Yes

SECTION RX: TIER #5 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Standard Retail Cost-Sharing 3-month supply:	25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:	25%
Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard Mail-Order Cost-Sharing 3-month supply:	25%

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-Network Pharmacy 1-month supply:	25%
Indicate Coinsurance percentage for Long-Term Care Pharmacy 1-month supply:	25%

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Tier Includes:	Part D Drugs Only
Tier Drug type(s) (select all that apply):	: Generic : Brand
Indicate the type of cost-sharing structure:	Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:	: Standard Retail/Preferred Retail Cost-Sharing - one month supply : Standard Retail/Preferred Retail Cost-Sharing - three month supply
Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:	: Out-of-Network Pharmacy - one month supply
Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):	: Standard Mail Order Cost-Sharing - three month supply
Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:	: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-month supply:	30
Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-month supply:	90
Are all of the drugs on your formulary for this tier available with an extended day supply?	Yes
Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order Cost-Sharing in your 3-month supply:	90

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network Pharmacy in your 1-month supply:	30
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail Cost-Sharing 1-month supply:	$10.00
Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:	$20.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 1-month supply:	$2.00
Indicate Copayment amount for Preferred Retail Cost-Sharing 3-month supply:	$4.00

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-Order Cost-Sharing 3-month supply:	$4.00

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network Pharmacy 1-month supply:	$10.00
Indicate Copayment Amount for Long-Term Care Pharmacy 1-month supply:	$2.00

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment	$0.33
Daily Preferred Retail Copayment	$0.07
Daily Copayment for Long-Term Care Pharmacy	$0.06

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost Threshold?	Medicare-defined Post Threshold Cost Shares

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Generic
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	1

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Generic

Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic
Tier Includes:	Part D Drugs Only
Tier ID - OOP	2

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	3

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Non-Preferred Brand
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	4

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Specialty Tier
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	5

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description	Select Care Drugs
Select the type of drug benefit:	Actuarially Equivalent Standard
Select drug type(s) in this Tier (select all that apply):	: Generic : Brand
Tier Includes:	Part D Drugs Only
Tier ID - OOP	6

SECTION RX: VBID PART D REWARDS AND INCENTIVES #1

Do you offer Part D Rewards and Incentives programs through the model?	No

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D reductions in cost?	No