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

Section B2 Status

Completed
Section B3 Status

Completed
Section B4 Status

Completed
Section B5 Status

Completed
Section B6 Status

Completed
Section B7 Status

Completed
Completed
Completed

Section B8 Status Completed
Section B9 Status Completed
Section B10 Status Completed
Section B11 Status Completed
Section B12 Status Completed

Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed

Section B14 Status Completed
Section B15 Status Completed
Completed
Completed

Section B17 Status Completed
Section B18 Status Completed
Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1





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

TRIPLE S ADVANTAGE, INC.
Triple S Advantage
www.sssadvantage.com
Platino Plus (HMO D-SNP)
Local CCP
HMO
Part A and Part B

Part A and Part B
40010 - Adjuntas, PR
40020 - Aguada, PR
40030 - Aguadilla, PR
40040 - Aguas Buenas, PR

40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR

40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR

40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR

40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR

40250 - Dorado, PR 40260 - Fajardo, PR

40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR 40310 - Gurabo, PR

40320 - Hatillo, PR



Service Area(s): Service Are

40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR

40640 - San Juan, PR

40650 - San Lorenzo, PR

40670 - Santa Isabel, PR

40680 - Toa Alta, PR

40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Viegues, PR

40660 - San Sebastian, PR



	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	024
Segment ID:	0
Contract Period:	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 2	

SECTION A: SECTION A-3

Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for	(888)620-1919

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

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

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

710000000000000000000000000000000000000	
Customer Service Contact Local Phone Number	(877)207-8777
for Prospective Medicare Beneficiaries:	

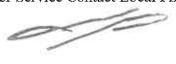
Customer	Service Contact Phone Number for	(888)620-1919
Current P	art D Medicare Beneficiaries:	

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

Customer Service Contact Phone Number for	(877)207-8777
Prospective Part D Medicare Beneficiaries:	

SECTION A: SECTION A-4

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



for Prospective Part D Medicare Beneficiaries:		
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
SECTION A: SECTION A-5		
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

m





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

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost 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

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?

- . .

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

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?

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

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

No

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

No

Out-of-Pocket Cost?

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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







Notes:

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

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

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

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

amount:

75.00

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

Is there an enrollee Deductible?

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

Worldwide services are covered through Notes:

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2



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

Yes

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Is a referral required for Occupational Therapy Services?

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





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

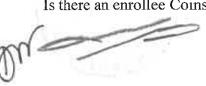
Is authorization required? No
Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required? No Yes

Is a referral required for Other Health Care

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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 No

Out-of-Pocket Cost?

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

Yes Is authorization required?

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may : 7a: Primary Care Physician Services : 7d: Physician Specialist Services have Additional Telehealth Benefits available:

: 7e1: Individual Sessions for Mental Health

Specialty Services

: 7h1: Individual Sessions for Psychiatric

No

No

: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

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

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

No Is there an enrollee Coinsurance? 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

No

Telehealth Services?

Is a referral required for Additional Telehealth

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

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

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

Is there an enrollee Coinsurance?

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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	E ABUSE - BASE 2	
Is there an enrollee Coinsurance?	No	

E - 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 No Abuse?

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

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

Three (3) Pint Deductible Waived

Yes

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Select enhanced benefit:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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







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

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Any Health-related Location

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 24

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-One-way

related Location:

Select Mode of Transportation for Any Health-: Taxi

related Location:

: Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Is a referral required for Transportation

Services?

Other method of transportation is available in an

automobile through a contracted provider.



Notes:

SECTION B: #11A DME - BASE 1

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

SECTION B: #11A DME - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Is authorization required?

Notes:

Yes

No

Yes

0%

5%

0%

5%

No No

Yes

0% coinsurance for preferred brands and

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

manufacturers.

5% coinsurance for non preferred brands and

manufacturers.

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

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

Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

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 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 No

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

Yes

supplemental benefit under Part C?

Select enhanced benefit:

: Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of

No

Treatments?

Indicate limit for Number of Treatments:

12

Indicate Number of Treatments periodicity:

Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

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



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

SECTION B: #13B OTC ITEMS - BASE 1

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

limit with Alternative therapy benefit.

Mandatory

Yes

Yes

75.00

Every three months

No

No

Yes

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

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OTC or formulary drugs.

No No No

No

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



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

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

SECTION B: #13E OTHER 2 - BASE 1

Enter name of Service (Optional): Select type of benefit for Other 2:

COVID-19 Food Allowance

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

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.

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SECTION B: #13F OTHER 3 - BASE 1

Enter name of Service (Optional): Select type of benefit for Other 3:

Covid-19 Delivery Charge Payment

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





No Is there an enrollee Copayment? 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?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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)*

Mandatory: Mandatory

No

Yes

: 14c9: Counseling Services : 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary No, indicate number

Benefit? Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

Individual Sessions

Mandatory

: Nursing Hotline

Mandatory

Yes



Indicate setting for Counseling Services: Individual Sessions

Indicate duration of sessions (in minutes): 20

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

Is your Alternative Therapies benefit combined

with either the Chiropractor Services benefit or

Acupuncture benefit, or both?

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

Yes

Is there a service-specific Maximum Plan No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

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

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

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

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

Supplemental Benefits?

Health Education Notes:



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

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

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



emergency room, or they will offer you self-care

instructions to help alleviate your

symptoms safely, in the comfort of your home.

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?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

Education Services?



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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

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



Glaucoma Screening?

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

No

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Is there an enrollee Deductible? No

Is Authorization Required? Yes Does the plan offer step therapy? Yes

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

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

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

Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

> : Prophylaxis (Cleaning) : Fluoride Treatment

: Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

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

Indicate number of visits for Oral Exams:

Every six months Select the Oral Exams periodicity:

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

M -

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

Is this benefit unlimited for Fluoride Treatment?

No, indicate number

Indicate number of visits for Fluoride

1

1

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays: 1

Select the Dental X-Rays periodicity: Other, Describe

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Oulei, Describe

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

Is a referral required for Preventive Dental

Services?

Notes: Up to (1) Panoramic image or Intraoral

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

images or Intraoral complete series, the

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

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bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits:

Yes

Non-routine Services

: Diagnostic Services

: Restorative Services

: Endodontics

Periodontics

Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services





Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine

Services?

Yes

Select type of benefit for Diagnostic Services:

Is this benefit unlimited for Diagnostic

Services?

Mandatory

Mandatory

Yes

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics.

Other Oral/Maxillofacial Surgery, Other

Services?

Yes

Mandatory

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage

amount:

2500.00

No

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Every year

Plan-specified amount per period

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental No

Services?

Notes: Restorative: Amalgams and Composites Resin

restorations-every 24 months, Core build up and

Pin retention-1 per tooth every 5 years,

KN-

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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.



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

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

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity: Enter name of Other Service:

Select type of benefit for Other Service: Is this benefit unlimited for Other Service? Indicate quantity for Other Service: Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year
Eyewear eye exam
Mandatory
No, indicate number





Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? Is a referral required for Eye Exams?

Notes:

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:

Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames:

Is this benefit unlimited for Eyeglass frames?

Select type of benefit for Upgrades:

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Every year

No

No

No

No

No

No

No

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

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses

: Eyeglass frames

: Upgrades

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

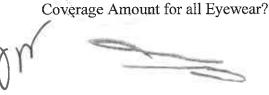
Mandatory

Yes

Plan-specified amount per period

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Yes



Indicate Combined Maximum Plan Benefit 850.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: **SECTION B: #17B EYEWEAR - BASE 4** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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 Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: 1 Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No

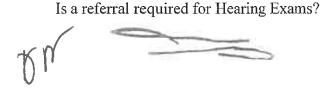
No

No

No

No





Is authorization required?

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

SECTION B: #18A HEARING EXAMS - BASE 3

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

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 Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically Ill?

: Additional Benefits Select what type of benefit your SSBCI

includes:

Are you offering a VBID Hospice Benefit? Yes Are you offering Part C benefits under the No

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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



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

No

Does your organization offer provider

incentives for offering or engaging beneficiaries in WHP activities?

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?

PACKAGE #1

How many packages do your Additional

Benefits contain? (1-15)

Yes

2



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0.0

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

No

diseases selected to qualify? If yes, describe in

notes.

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:



Benefit eligibility will be based on medical recommendation, and the following conditions:

- Post Inpatient stay 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

Yes

Supplemental Benefits as a benefit under Part

C?

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

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

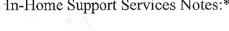
Is a referral required for Other Defined

No

Supplemental Benefits?

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

In-Home Support Services Notes:*





Benefit consists 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

SSBCI

Uniformity Flexibility or SSBCI?

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

Is there a prerequisite for any additional benefits

No

for this package?

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

No

deductible?

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-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

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

Contrato Número

Select type of benefit for Other 1:

Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

225.00

amount:

Select Maximum Plan Benefit Coverage

Every three months

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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?

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?

Is there an enrollee Copayment?

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

No



SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees that elect hospice?

Enter the Maximum plan benefit amount:

Are hospice supplemental benefits contingent upon receiving services from an in-network

provider?

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.

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.

Reduced cost sharing for unrelated medical care services received during hospice election

Other mandatory supplemental benefits

Describe other mandatory supplemental

benefits:

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes

Yes

0.00

Yes

No

No

No

Yes

In-Home Support

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

No Do you offer a US Visitor/Travel Program?

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?

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Yes

Voluntary

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?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Yes

Amount?

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

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

: 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?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Is prior authorization required for certain

prescription drugs?

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

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

Do you pay for over-the-counter medications (OTCs) under the utilization management program?

OTC Medication Attestation statement

Yes

No

Yes

Yes

No

Yes

Yes

Contrato Número

: 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



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 costsharing level for all generic drugs approved for

formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to

select):

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

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

No

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

Tier Label Description

Select the type of drug benefit:

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

Indicate the type of cost-sharing structure:

Preferred Generic

Actuarially Equivalent Standard

Part D Drugs Only : Generic

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

30

90

: Standard Retail/Preferred Retail Cost-Sharing -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

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

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-



month supply:

Are all of the drugs on your formulary for this

S

tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

No

Yes

supply for the first fill?

SECTION RX: TIER #1 - 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 #1 - 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

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$28.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$14.00

Contrato Número

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

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

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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 Tior (Optional):

: Standard Mail Order Cost-Sharing - three month supply

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

: Long Term Care Pharmacy - one month supply

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

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-month supply:

Enter number of days for Standard 90

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?

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

supply for the first fill?

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

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

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$20.00 Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

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



Contrato Número m

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

\$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 \$0.48

Pharmacy

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

Tier Label Description

Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Includes:

Part D Drugs Only

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

Congressons

: 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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

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?

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

supply for the first fill?

Yes

No

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

Enter number of days for Standard Mail-Order

Cost-Sharing in your 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:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

30

\$47.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$84.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Non-Preferred Brand Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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:

Select all Out-of-Network Pharmacv

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 Retail/Preferred Retail Cost-Sharing -

Contrato Número

one month supply

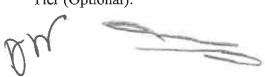
: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply



Select all Long-Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

Yes

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?

SECTION RX: TIER #4 - 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 #4 - 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

31

Pharmacy 1-month supply:

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

\$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

DU ==

Pharmacy

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

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Tier Includes: Part D Drugs Only

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

: 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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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

supply for the first fill?

Yes

Yes

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

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

30

Pharmacy 1-month supply:

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 25%

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard 25%

Mail-Order Cost-Sharing 3-month supply:

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

25%

Indicate Coinsurance percentage for Out-of-

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

Care Pharmacy 1-month supply:

25%

care i harmaey 1-month supply.

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

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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 Pharmany Location (symply amounts)

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

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

30

90





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

supply for the first fill?

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:

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

Enter number of days for Out-of-Network

30

90

No

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

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Pharmacy 1-month supply:

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

ICL

Indicate Copayment amount for Standard Retail \$8.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$16.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$3.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$6.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail- \$6.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$3.00

Care Pharmacy 1-month supply:

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 \$0.10

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

The ID 3001

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):

Tier Includes:

Part D Drugs Only

: Generic

Tier ID - OOP

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 : Brand

apply):

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 : Brand

apply):

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 No

programs through the model?

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D No

reductions in cost?







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

Completed

DMINISTRAC

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Upload Status: 06/01/2020 #02500

PLAN STATUS

Section A Status Plan Ready for Upload

Completed Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Section B5 Status Completed Completed Section B6 Status Completed Section B7 Status Section B8 Status Completed Completed Section B9 Status Completed Section B10 Status Section B11 Status Completed

Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed
Section B15 Status Completed

Section B17 Status Completed
Section B18 Status Completed
Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1



- Section B16 Status

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

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

40290 - Guayanilla, PR

40300 - Guaynabo, PR 40310 - Gurabo, PR

40320 - Hatillo, PR



Service Area(s):
Service Area(s):
Service Area(s)
De la companya della companya della companya de la companya della

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

40670 - Santa Isabel, PR

40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR



	40750 Will-II- DD
Carrier Array(a)	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	

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number

(877)207-8777



for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries: SECTION A: SECTION A-5	(866)620-2520
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-AC	CUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes
SECTION B: #1A INPATIENT HOSPITAL-AC	CUTE - BASE 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No

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

No

No

Is there an enrollee Coinsurance?

Does this plan's Additional Days cost sharing



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

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

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

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay period?

Do you charge cost sharing on the day of No discharge?

Is authorization required? No
Is a referral required for Inpatient HospitalNo
Acute Services?

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

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit under Part C?

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

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

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

Is there an enrollee Coinsurance?

No

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

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

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay benefit period?

Do you charge cost sharing on the day of discharge?

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

SECTION B: #2 SNF - BASE 1

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

Do you allow less than 3 day inpatient hospital No stay prior to SNF admission?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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?

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?

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

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

No

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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 No

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment? No

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





Services in the USA may also be available Notes:

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

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

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

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

amount:

75.00

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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

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

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

Worldwide services are covered through Notes:

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

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

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 No

Out-of-Pocket Cost?

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 Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care
Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined No

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? 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 No

Services?

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

MM -



Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? Yes

Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? 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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

The there are enrolled Constitution



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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

No

No

No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may : 7a: Primary Care Physician Services have Additional Telehealth Benefits available: : 7d: Physician Specialist Services

: 7e1: Individual Sessions for Mental Health

Specialty Services

: 7h1: Individual Sessions for Psychiatric

Services

No

: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

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

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

Is there an enrollee Coinsurance?

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

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No Is there an enrollee Deductible? No

Is there an enrollee Copayment?

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

Is there an enrollee Coinsurance?

No

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Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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	E ARUS

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

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

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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







Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Any Health-related Location

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 24

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health- One-way

related Location:

Select Mode of Transportation for Any Health- : Taxi

related Location: : Van

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

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

Medicare-covered Benefits:

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?

0% coinsurance for preferred brands and Notes:

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

Yes

Yes

Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

5% 0%

0%

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

5% coinsurance applies to surgically implanted Notes:

> prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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

Is there an enrollee Copayment? No
Do you limit Diabetic Supplies and Services to
Yes

those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Is a referral required for Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with Yes either the Chiropractor Services benefit or

Alternative Therapies benefit, or both?

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 there an enrollee Copayme

Is authorization required?
Is a referral required for Acupuncture?

No 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?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

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

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

Nicotine Replacement Therapy (NRT)

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Mandatory

Yes

75.00

Every three months

No

No

Yes

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

No

No

No

No



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

DW -

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

No

No

SECTION B: #13E OTHER 2 - BASE 1

Covid-19 Food Allowance Enter name of Service (Optional): Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

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

SECTION B: #13E OTHER 2 - BASE 3

Benefit consists of a \$50 allowance for the Notes: 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

> > Contrato Número

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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 10.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

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

SECTION B: #13F OTHER 3 - BASE 2

Is there an enrollee Coinsurance? No No

Is there an enrollee Deductible?

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? Nο 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?

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

Does the plan provide Other Defined

C?

Yes Supplemental Benefits as a benefit under Part

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

Contrato Número

Hotline)*

No

: 14c9: Counseling Services : 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

6

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

: Nursing Hotline

Mandatory

Mandatory

Yes



Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

Is your Alternative Therapies benefit combined

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

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:



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

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

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

01

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

No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

No

Education Services?

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

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

Preventive Services?

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

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

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

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





Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

Is authorization required for Other Medicare-

covered Preventive Services?

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

Is a referral required for any Services?

No

No

No

No

No

No

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

Is there a Maximum Enrollee Out-of-Pocket

Cost?

Is there an enrollee Coinsurance?

No

No

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

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

Yes Is Authorization Required? Does the plan offer step therapy? Yes

Does the benefit step from (select all that : Part B to Part B? : Part B to Part D? apply):

Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

Yes

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:

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Contrato Número

Mandatory

No, indicate number



Indicate number of visits for Prophylaxis

(Cleaning):

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

1

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

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

Indicate number of visits for Dental X-Rays: 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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

Is a referral required for Preventive Dental No

Services?

Notes: Up to (1) Panoramic image or Intraoral

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

images or Intraoral complete series, the

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

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits:

Yes

: Non-routine Services

: Diagnostic Services

Restorative Services

Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

6 P



Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

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:

Is this benefit unlimited for Prosthodontics,

Yes

Other Oral/Maxillofacial Surgery, Other

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

3000.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes:

Restorative: Amalgams and Composites Resin restorations-every 24 months. Core build up and

Contrato Número

Pin retention-1 per tooth every 5 years,

1

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? Select enhanced benefit:

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

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity: Enter name of Other Service:

Select type of benefit for Other Service: Is this benefit unlimited for Other Service? Indicate quantity for Other Service:

Indicate quantity for other service

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year
Eyewear eye exam
Mandatory
No, indicate number
1



Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? 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.

Every year

No

No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Mandatory

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Yes

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory Is this benefit unlimited for Eyeglass lenses? Yes

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes Select type of benefit for Upgrades: Mandatory

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?

Yes

Plan-specified amount per period

Yes





Indicate Combined Maximum Plan Benefit 1000.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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 Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? 1 Indicate number for Routine Hearing Exams: Every year Select Routine Hearing Exams periodicity: Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3** Is there an enrollee Copayment? No

No

No

Is authorization required?

Is a referral required for Hearing Exams?



SECTION B: #18B HEARING AIDS - BASE 1

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

subplemental benefit under

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

Both ears combined

Does the Maximum Plan Benefit Coverage

combined?

Amount apply per ear or for both ears

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?

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 Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically Ill?

Select what type of benefit your SSBCI : Additional Benefits

includes:

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the No

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

M



: 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

No

Does your organization offer provider

incentives for offering or engaging beneficiaries in WHP activities?

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

No

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

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

reductions in cost?

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

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 Contrato Número

Other 4 Description: Hip Surgery
Other 5 Description: Knee Surgery

Does the enrollee need to have all diseases

selected to qualify?

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in

No

No

No

notes.

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

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

deductible?

Yes

Select all the Non-Medicare-covered additional

benefits that are exempt from the plan-level

deductible:

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

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

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POSDE

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 Yes

C?

Select enhanced benefit (Select all that apply): : 14c21: In-Home Support Services*

Select enhanced benefit (Sele

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

Select type of benefit for In-Home Support

Mandatory

Services:

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

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

In-Home Support Services Notes:*



Benefit consists 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

SSBCI

Uniformity Flexibility or SSBCI?

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

DN -

Is there a prerequisite for any additional benefits

for this package?

: 13i-O: Non-Primarily Health Related Benefits

Select all the Non-Medicare-covered additional

for the Chronically Ill (Other)

benefits offered in this package:

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

No

No

No

No

deductible?

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

Are you offering retroactive reimbursement?

Is there a maximum benefit amount?

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

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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-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 225.00

amount:

Select Maximum Plan Benefit Coverage Every three months

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

5 M

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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?

Is authorization required?

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?

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?

0.00 Enter the Maximum plan benefit amount: Are hospice supplemental benefits contingent

upon receiving services from an in-network provider?

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.

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.

Reduced cost sharing for unrelated medical care services received during hospice election

Other mandatory supplemental benefits Describe other mandatory supplemental

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes

Yes

Yes

No

No

No

Yes

In-Home Support

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.

In-Home Support Benefit -The benefit consists

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?

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Yes Voluntary



511

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

No

Amount?

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:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

: 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?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Is prior authorization required for certain

prescription drugs?

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

design)?

Do any drugs in your formulary require a step

therapy plan?

Do you pay for over-the-counter medications (OTCs) under the utilization management

program?

OTC Medication Attestation statement

Yes

Yes

No

Yes

No

Yes

Yes

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

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OSDES

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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?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6 4

What is your Formulary Exception Tier?

Do you apply a second less expensive costsharing level for all generic drugs approved for

formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to

select):

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

Care Drugs

Yes

No

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

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

Preferred Generic Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three

month supply

30

: 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 1month supply:

M

POSDE

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

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

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$28.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$14.00

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Care Pharmacy 1-month supply:

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

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

Pharmacy

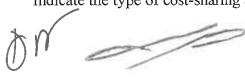
SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Generic

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

: Out-of-Network Pharmacy - one month supply

Tier:

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

: Standard Mail Order Cost-Sharing - three month supply

Select all Long-Term Care Pharmacy

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

: Long Term Care Pharmacy - one month supply

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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:

Enter number of days for Standard

90

30

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 #2 - 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 #2 - 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

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$15.00

Cost-Sharing 1-month supply:

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-

\$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:

Indicate Copayment Amount for Long-Term

\$15.00

\$20.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

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 -

Out-of-Network Pharmacy - one month supply

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: 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 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

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?

Are any of the drugs available at an extended

No

Yes

90

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order 90



Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

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

\$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing 1-month supply:

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-

\$84.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$42.00

\$47.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$1.57

Daily Preferred Retail Copayment \$1.40

Daily Copayment for Long-Term Care \$1.35

Pharmacy

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

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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)

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

: Standard Retail/Preferred Retail Cost-Sharing -

DMINISTR40

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing

Location/supply amount(s) that apply for this

: Standard Mail Order Cost-Sharing - three

month supply

Tier (Optional):

Select all Long-Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

POSDE

Location/supply amount(s) that apply for this

Tier:

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

Yes

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment

\$3.33

Daily Preferred Retail Copayment

\$3.17

DN

Daily Copayment for Long-Term Care

Pharmacy

\$3.06

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

Specialty Tier Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

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

: Brand

Coinsurance Indicate the type of cost-sharing structure:

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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

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

Long Term Care Pharmacy - one month supply

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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

supply for the first fill?

Yes

Yes

SECTION RX: TIER #5 - 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 #5 - 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

31

Pharmacy 1-month supply:

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

ICL

25% Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 3-month supply:

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

25%

Indicate Coinsurance percentage for Standard

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of-25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term 25%

Care Pharmacy 1-month supply:

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

Tier Label Description Select Care Drugs

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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:

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

> > 90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Standard Mail Order Cost-Sharing - three

month supply

one month supply

: Long Term Care Pharmacy - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Standard Retail/Preferred Retail Cost-Sharing -

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this Yes



tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

No

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

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

ICL

Indicate Copayment amount for Standard Retail \$6.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$12.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$2.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$4.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$4.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$2.00

: Generic

Care Pharmacy 1-month supply:

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 \$0.06

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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 : Brand

apply):

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 : Brand

apply):

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

No

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?

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D No

reductions in cost?







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

- 0 0

Upload Status: 06/01/2020 #02500

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Completed Section B3 Status Section B4 Status Completed Completed Section B5 Status 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: Organization Marketing Name: Organization Web Site: Plan Name: Organization Type: Plan Type: Enrollee Type: Service Area(s): Service Area(s):

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Advance (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranguitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR

40280 - Guayama, PR 40290 - Guayanilla, PR

40300 - Guavnabo, PR

40310 - Gurabo, PR 40320 - Hatillo, PR



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

40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR

40650 - San Lorenzo, PR

40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR



	40750 - Villalba, PR		
Service Area(s):	40760 - Yabucoa, PR		
Service Area(s):	40770 - Yauco, PR		
Contract Number:	H5774		
Plan ID:	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		



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	Yes

tiered cost sharing:
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

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

Select the benefits that have tiered cost sharing:

Select the Medicare-covered benefits that have

cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered

in Section B of the PBP software)

te Yes

: Medicare-covered

: 7f: Podiatry Services

C?

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 No

Out-of-Pocket Cost?

C+ --+

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

obtains care?



Is there an enrollee Coinsurance?

No

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?

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

No

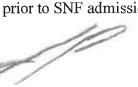
Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?





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

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

Contrato Númer

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsulance?



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

Is there an enrollee Copayment?

No

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

Notes: Services in the USA may also be available

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

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Yes

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

Is there an enrollee Deductible?

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 No

Out-of-Pocket Cost?

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 Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

No

Copayment (Select all that apply):

Indicate Minimum Copayment amount for \$2.00

Medicare-covered Benefits:

Indicate Maximum Copayment amount for \$2.00

Medicare-covered Benefits:

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

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





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Occupational Therapy No

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Yes

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2



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

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

Copayment (Select all that apply): : Routine Foot Care

Indicate Minimum Copayment amount per visit

for Medicare-covered Benefits:

Indicate Maximum Copayment amount per visit \$2.00

for Medicare-covered Benefits:

Indicate Minimum Copayment amount per visit \$0.00

for Routine Foot Care:

Indicate Maximum Copayment amount per visit \$0.00

for Routine Foot Care:

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.

No

\$0.00

\$2 copay for Medicare covered services.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required? Yes No

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

SECTION B: #7.I ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit Yes

for Part B services?

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

No

Yes

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?

Is a referral required for Additional Telehealth

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is authorization required? No

Is a referral required for Opioid Treatment No

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? Yes

Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?



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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

Select enhanced benefit:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

Any Health-related Location

Select type of benefit for Any Health-related

Mandatory

Location:



Is this benefit unlimited for number of trips for No Any Health-related Location?

Indicate number of trips for Any Health-related 10

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-One-way

related Location: Select Mode of Transportation for Any Health-

: Van related Location: : Other, Describe

: Taxi

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance? 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 No

Services?

Other method of transportation is available in an Notes:

automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance? 0% Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 10%

Medicare-covered Benefits:

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

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Yes

Durable Medical Equipment (DME)?

Yes Is authorization required?

0% coinsurance for preferred brands and Notes:

manufacturers.

10% coinsurance for non preferred brands and

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manufacturers.

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

Is there a service-specific Maximum Enrollee No



Out-of-Pocket Cost?

Yes Is there an enrollee Coinsurance?

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

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

10%

Medicare-covered Medical Supplies:

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

10% coinsurance applies to surgically implanted Notes:

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

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

0% coinsurance for Cardiovascular Devices.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No

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

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

Is there an enrollee Copayment? No Yes

Do you limit Diabetic Supplies and Services to

those from specified manufacturers?

No

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No No

Is there an enrollee Copayment?





SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a No

supplemental benefit under Part C?

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) No Items as a supplemental benefit under Part C?

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal
Benefit as a supplemental benefit under Part C?
Note: Only primarily health-related meals

offered in accordance with Chapter 4 of the MMCM should be entered in this section.

SECTION B: #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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

Is there an enrollee Coinsurance?

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

DECITO: I DE CITERE DE DECE

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

Yes

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?

Indicate Maximum Plan Benefit Coverage 10.00

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

SECTION B: #13F OTHER 3 - BASE 3

Benefit consists of a \$10 allowance to pay for Notes:

> 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

: I attest that there is no coinsurance, Medicare-covered Zero Dollar Preventive

copayment, or deductible for all Original Services Attestation

Medicare preventive services that are offered at

zero dollar cost sharing.

No Is authorization required? 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?

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

Does the plan provide Other Defined Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

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

Hotline)*

6

No

: 14c9: Counseling Services

Mandatory Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit: Individual Sessions

No, indicate number

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Mandatory

Select type of benefit for Counseling Services:

Mandatory Yes

Is this benefit unlimited for Counseling

Services?

Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

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

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

Remote Access Technologies (Nursing Hotline) Notes:

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

instructions to help alleviate your symptoms

safely, in the comfort of your home.

Teleconsejo (Emotional Support Line) - 24/7 Counseling Services Notes:

access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate

available community services.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

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

Glaucoma Screening?

Is authorization required for Medicare-covered No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?

Is authorization required for Other Medicare-No

covered Preventive Services?

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

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?

Is there an enrollee Coinsurance?

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

No

Yes

1

Is there an enrollee Copayment?

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?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

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

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams?

No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

Is this benefit unlimited for Fluoride Treatment? No, indicate number

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

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

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity: Other, Describe

Is there a service-specific Maximum Plan No

m ==



Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is authorization required?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is a referral required for Preventive Dental No

Services?

Notes: Up to (1) Panoramic image or Intraoral

No

No

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

images or Intraoral complete series, the

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

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Yes

Items as a supplemental benefit under Part C?

Select enhanced benefits: : Non-routine Services

Diagnostic Services
Restorative Services

: Endodontics : Periodontics : Extractions

Yes

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine

Services?

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic Yes

Services?

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes





Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Yes

Other Oral/Maxillofacial Surgery, Other

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes Is a referral required for Comprehensive Dental

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?

Select enhanced benefit:

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

Yes

: Routine Eye Exams

: Other

Mandatory

No, indicate number

1

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

Every year

No

No

No

No No

No

No

The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will



26

cover under the Other eye exam, consultation and prescription for eyewear including refraction.

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses

: Eyeglass frames

: Upgrades

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

Mandatory Yes

Mandatory

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:

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?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear?

Yes

Mandatory

Yes

Plan-specified amount per period

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- 0 0

Yes

100.00

Every year

No

No

No

No

No

No



SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams

Select type of benefit for Routine Hearing

Mandatory

Yes

Exams:

Is this benefit unlimited for Routine Hearing

-

Exams?

Indicate number for Routine Hearing Exams:

No, indicate number

Select Routine Hearing Exams periodicity: Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan N

Benefit Coverage amount?

No

1

Is there an enrollee Deductible?
Is there a service-specific Maximum Enrollee

No No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

nere an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3Is there an enrollee Copayment? No

Is authorization required?

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

Yes

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

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for No

the Chronically Ill?

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)

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

OSDE

or Socioeconomic Status

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program

: In-home Assessments

WHP Mode of Engagement (choose one or Telephonic

8 C

more):

: In-Person : Web-Based

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

No

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

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

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

Which disease states does this benefit apply?

(Select all that apply):

Other 1 Description:

: Chronic Obstructive Pulmonary Disease

0 1

(COPD)

: Congestive Heart Failure (CHF)

: Other 1

: Other 2

Other 3

: Other 4

: Other 5

Oncology patients with active chemo by

infusion

Acute Stroke Other 2 Description:

Other 3 Description: Open Heart Surgery

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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

ts No

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

Benefit eligibility will be based on medical recommendation, and the following conditions:

- Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home

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

Yes

Supplemental Benefits as a benefit under Part

C?

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?

BASE 6: PACKAGE #1

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

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

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

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

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

Supplemental Benefits?

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

In-Home Support Services Notes:*



Benefit consists 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

: Chronic Condition(s)

both:

Which disease states does this benefit apply?

: Other CMS-Approved Disease State

(Select all that apply):

Expected Number of Enrollees to be Targeted: 1263 Expected Number of Enrollees to be engaged 1263

on -

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 No

for this package?

Select all the Non-Medicare-covered additional

: 13d: Other 1

benefits offered in this package:

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

No

deductible?

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 Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 160.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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



Is there an enrollee Coinsurance?

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?

0.00

Enter the Maximum plan benefit amount:

Are hospice supplemental benefits contingent upon receiving services from an in-network provider?

Yes

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

In-Home Support

benefits:

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 Outof-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

No

Amount?

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:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

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?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Is prior authorization required for certain

prescription drugs?

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

design)?

Do any drugs in your formulary require a step

therapy plan?

Do you pay for over-the-counter medications (OTCs) under the utilization management

program?

OTC Medication Attestation statement

Yes

Yes

Yes

No

No

Yes

Yes

Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC

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drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Yes

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

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6
What is your Formulary Exception Tier? 4

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





SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

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

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

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

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

Cost Share Tiers

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:

that apply for this fier.

: 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 #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

DM -

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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

No

Yes

supply for the first fill?

SECTION RX: TIER #1 - 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 #1 - 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

31

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Pharmacy 1-month supply:

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

ICL
Indicate Copayment amount for Standard Retail \$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$28.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail- \$28.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$14.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

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

Tier Label Description Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment

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

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

that apply for this Tier:

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

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3month supply:

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

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

supply for the first fill?

Yes

No

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

90 Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

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-

\$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

\$20.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$15.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Preferred Brand Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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 -

Out-of-Network Pharmacy - one month supply

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

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

month supply:

Enter number of days for Standard

90

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

No

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

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 \$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail- \$84.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$1.57

Daily Preferred Retail Copayment \$1.40

Daily Copayment for Long-Term Care \$1.35

Pharmacy

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

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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 -

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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

dn -

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

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

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

Yes

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

ICL

\$100.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$190.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:



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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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

supply for the first fill?

Yes

Yes

SECTION RX: TIER #5 - 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 #5 - 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 31

Enter number of days for Long-Te

Pharmacy 1-month supply:

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

25%

25%

25%

25%

25%

25%

25%

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of-

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

Care Pharmacy 1-month supply:

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

Select Care Drugs Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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

: 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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing

Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

30

Contrato Número

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

No

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$10.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$20.00

\$5.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$10.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$10.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network \$10.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$5.00

Care Pharmacy 1-month supply:

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 \$0.16

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

DN -

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

: Generic

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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 : Brand

apply):

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 : Brand

apply):

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

No

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?

SECTION RX: VBID - GENERAL







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

DMINISTR

Contrato Número

Upload Status: 06/01/2020 #02500

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status

Section B2 Status

Completed

Section B3 Status

Completed

Section B4 Status

Completed

Section B5 Status

Completed

Section B6 Status

Completed

Section B7 Status

Completed

Completed

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

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

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Blindao (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR

40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR



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

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

40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR



	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	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



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-A	CUTE - BASE 2	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No	
Is there an enrollee Coinsurance?	No	
	ANTITOTAL TO A CONTROL OF	

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

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 No Is there an enrollee Copayment?

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

What is your Inpatient Hospital-Acute benefit Per Admission or Per Stay period?

Do you charge cost sharing on the day of No discharge?

Is authorization required? No Is a referral required for Inpatient Hospital-No Acute Services?

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

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit under Part C?

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

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

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

Is there an enrollee Coinsurance? No

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

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

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay benefit period? Do you charge cost sharing on the day of No discharge? Is authorization required? No

Is a referral required for Inpatient Psychiatric No Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility No Services as a supplemental benefit under Part C? A 112

Do you allow less than 3 day inpatient hospital No stay prior to SNF admission?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?





Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

No

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Notes: Services in the USA may also be available

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

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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





Notes:

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

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

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

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

amount:

75.00

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

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

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

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

Notes:

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

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

No

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

No

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? 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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may : 7a: Primary Care Physician Services have Additional Telehealth Benefits available: : 7d: Physician Specialist Services

: 7e1: Individual Sessions for Mental Health

Specialty Services

: 7h1: Individual Sessions for Psychiatric

Services

No

: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

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

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

Is there an enrollee Coinsurance?

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

No

Telehealth Services?

Is a referral required for Additional Telehealth

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

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

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? 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 Shire	

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

No

No

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The

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?
Is a referral required for Outpatient Blood

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

Yes

as a supplemental benefit under Part C?

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

20

Indicate number of trips for Any Health-related

Location:

Every year

periodicity:

Select Type of Transportation for Any Health-

Select Any Health-related Location Trips

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 No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No

Is authorization required? Yes
Is a referral required for Transportation No

Services?

Other method of transportation is available in an

automobile through a contracted provider.



Notes:

SECTION B: #11A DME - BASE 1

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

Is there an enrollee Coinsurance?

Indicate Minimum Coinsurance percentage for
Medicare-covered Benefits:

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 Yes Durable Medical Equipment (DME)?

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 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 0%

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for 5% Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Medical Supplies:
Indicate Maximum Coinsurance percentage for 5%

Medicare-covered Medical Supplies:

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 No

Out-of-Pocket Cost?

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 Yes

those from specified manufacturers?

Is authorization required? No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

Is there an enrollee Copayment? 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 Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Every year Indicate Number of Treatments periodicity:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with Yes

either the Chiropractor Services benefit or Alternative Therapies benefit, or both?

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? 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) Yes

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 40.00

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

: 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 No

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

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.



No

Yes

No

No

Yes

Every three months

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): Select type of benefit for Other 2:

COVID-19 Food Allowance Mandatory

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50.00

Other, Describe

amount:

Select Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

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

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

Yes

Benefit Coverage amount?

10.00

Indicate Maximum Plan Benefit Coverage amount:

Other, Describe

No

Select Maximum Plan Benefit Coverage periodicity:

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

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

Yes

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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 Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

No, indicate number

O

Individual Sessions

Mandatory

: Nursing Hotline

Mandatory

Yes



Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

Is your Alternative Therapies benefit combined

Yes

with either the Chiropractor Services benefit or

Acupuncture benefit, or both?

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:



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

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

Remote Access Technologies (Nursing Hotline) Notes:

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

emergency room, or they will offer you self-care

instructions to help alleviate your

symptoms safely, in the comfort of your home.

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

No

No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Jul-01-Pocket Cost?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

No

Education Services?

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

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





Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

No

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

No

Is there an enrollee Coinsurance?

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:

Is this benefit unlimited for Oral Exams?

Mandatory

No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity:

Every six months

Select type of benefit for Prophylaxis

Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis

No, indicate number

(Cleaning)?



Indicate number of visits for Prophylaxis

(Cleaning):

Every six months

Select the Prophylaxis (Cleaning) periodicity:

Mandatory

Select type of benefit for Fluoride Treatment: Is this benefit unlimited for Fluoride Treatment?

No, indicate number

Indicate number of visits for Fluoride

1

Treatment:

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Other, Describe

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

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?

Select enhanced benefits:

No

Is a referral required for Preventive Dental

No

Services?

Notes:

Up to (1) Panoramic image or Intraoral

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

images or Intraoral complete series, the

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

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bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?

: Non-routine Services

: Diagnostic Services

: Restorative Services

: Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

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?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1500.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

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? Select enhanced benefit:

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

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity: Enter name of Other Service: Select type of benefit for Other Service: Is this benefit unlimited for Other Service? Indicate quantity for Other Service: Yes

: Routine Eye Exams

Other

Mandatory

No, indicate number

1

1

Every year Eyewear eye exam Mandatory No, indicate number



De la

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? 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 physician to evaluate the need to have evewear. If evewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

Yes

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

The routine eye exam is the test performed by

: Eyeglass lenses : Eyeglass frames

: Upgrades

Every year

No

No

Select type of benefit for Contact lenses: Mandatory

Is this benefit unlimited for Contact lenses? Yes Select type of benefit for Eyeglasses (lenses and Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Is this benefit unlimited for Eyeglass lenses? Select type of benefit for Eyeglass frames: Is this benefit unlimited for Eyeglass frames?

Select type of benefit for Upgrades:

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?

Mandatory

Yes

Yes

Mandatory

Yes

Mandatory

Yes

Plan-specified amount per period

Yes





Indicate Combined Maximum Plan Benefit 500.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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 Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: 1 Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: **SECTION B: #18A HEARING EXAMS - BASE 2** Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3** Is there an enrollee Copayment? No

No

No

Is authorization required?

Is a referral required for Hearing Exams?



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

Mandatory

types):

Is this benefit unlimited for Hearing Aids (all

Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage

Both ears combined

Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

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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

No

the Chronically Ill?

Are you offering a VBID Hospice Benefit?

Yes

Are you offering Part C benefits under the

No

VBID Model? (VBID Part D Rewards and

Incentives programs should be entered in

Section Rx)

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

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

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

No

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

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

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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

No

notes.

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

Is there a prerequisite for any additional benefits

for this package?

No

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

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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

Yes

Supplemental Benefits as a benefit under Part

C?

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

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

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

In-Home Support Services Notes:*

Benefit consists 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?

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?

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

Yes

provider?

Coverage of primarily and non-primarily health

related items to ameliorate the

No

functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.

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

No

residence to discharge to.

Reduced cost sharing for unrelated medical care

services received during hospice election

No

Other mandatory supplemental benefits

Yes

Describe other mandatory supplemental

In-Home Support

benefits:

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 Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Yes

Amount?

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:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

: 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?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Yes

Yes

Yes

No

Is prior authorization required for certain prescription drugs?

No

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

design)?

Do any drugs in your formulary require a step

therapy plan?

Do you pay for over-the-counter medications (OTCs) under the utilization management program?

OTC Medication Attestation statement

Yes

Yes

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: 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

Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

What is your Formulary Exception Tier?

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

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

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

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) 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

6

No

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 -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

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

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

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

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #1 - 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 #1 - 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

31

Pharmacy 1-month supply:

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

ICL

Indicate Copayment amount for Standard Retail

\$15.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$30.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$10.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$20.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$20.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$15.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$10.00

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Care Pharmacy 1-month supply:

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 \$0.32

Pharmacy

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

Tier Label Description Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier 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 : Standard Mail Order Cost-Sharing - three month supply

Tier (Optional): Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

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

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

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3month supply:

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

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

No

90

Yes



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:

SECTION RX: TIER #2 - 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 31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing 3-month supply:

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

\$30.00 Indicate Copayment amount for Standard Mail-

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:

Indicate Copayment Amount for Long-Term

\$15.00

\$20.00

Care Pharmacy 1-month supply:

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

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

Pharmacy_

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

Preferred Brand Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

one month supply

: Standard Retail/Preferred Retail Cost-Sharing that apply for this Tier:

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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

supply for the first fill?

Yes

No

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

90 Enter number of days for Standard Mail-Order

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

30

Pharmacy in your 1-month supply:

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

\$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$84.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$84.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$47.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$42.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment

\$1.57

Daily Preferred Retail Copayment

\$1.40 \$1.35

Daily Copayment for Long-Term Care

Pharmacy

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

Tier Label Description

Non-Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier 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 -

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing

Location/supply amount(s) that apply for this

Tier (Optional):

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one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

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

Yes

supply for the first fill?

SECTION RX: TIER #4 - 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 #4 - 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

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

Specialty Tier Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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:

three month supply Select all Out-of-Network Pharmacy Out-of-Network Pharmacy - one month supply

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):

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

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Standard Retail/Preferred Retail Cost-Sharing -

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

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

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

Yes

SECTION RX: TIER #5 - 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 #5 - 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 31

Pharmacy 1-month supply:

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

Yes

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

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard

25%

25%

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

25%

Care Pharmacy 1-month supply:

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

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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

: Brand

Copayment Indicate the type of cost-sharing structure:

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

: Out-of-Network Pharmacy - one month supply

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

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing

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

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

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:

SECTION RX: TIER #6 - 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 31

Pharmacy 1-month supply:

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

OMINISTRACIO

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No

90

ICL

Indicate Copayment amount for Standard Retail \$8.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$16.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$2.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$4.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail- \$4.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$2.00

Care Pharmacy 1-month supply:

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 \$0.06

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

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 : Brand

apply):

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 : Brand

apply):

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 : Generic

apply): : 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 No

programs through the model?

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D No

reductions in cost?







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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

Completed

Upload Status: 06/01/2020 #02500

PLAN STATUS

Section B10 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 B11 Status Completed
Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed
Section B15 Status Completed

Section B16 Status Completed
Section B17 Status Completed
Section B18 Status Completed
Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1



Organization Legal Name: Organization Marketing Name: Organization Web Site: Plan Name: Organization Type: Plan Type: Enrollee Type: Service Area(s): 40190 - Ciales, PR Service Area(s): Service Area(s):

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Enlace (HMO D-SNP) Local CCP **HMO**

Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR

40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR

40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR

40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR

40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR

40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR 40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR





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

Service Area(s):

Service Area(s):

Service Area(s):

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

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

40730 - Vega Baja, PR

40740 - Vieques, PR



	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	032
Segment ID:	0
Contract Period:	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			

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

No

No

Is there an enrollee Coinsurance?

Does this plan's Additional Days cost sharing



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

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

No

sharing vary by hospital(s) in which an enrollee

obtains care?

No

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

Is there an enrollee Deductible?

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part No

C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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 No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Notes:

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

were provided.

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

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

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

Notes:

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

No

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

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2





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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes No

Is a referral required for Home Health Services?

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

Yes

No

Yes

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Servicés as a

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

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

Indicate number of visits for Routine Care:

Every year Select Routine Care periodicity:

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

Is there a service-specific Maximum Enrollee No

Is a referral required for Chiropractic Services?

Out-of-Pocket Cost?

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 No

Services?

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



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

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

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

Is authorization required?

Yes
Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 No

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

No

Select type of benefit for Routine Foot Care: Mandatory

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

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required?

Is a referral required for Podiatrist Services? Yes

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required?

No

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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?

Nο No

Is a referral required for Psychiatric Services? SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Speech-Language Pathology Services?

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

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

Select the Medicare-covered benefits that may

: 7a: Primary Care Physician Services have Additional Telehealth Benefits available: : 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

No

Out-of-Pocket Cost?

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

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

Is authorization required?

No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Outpatient

No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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





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

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

No

No

Is there a service-specific Maximum Enrollee

Is a referral required for Ambulatory Surgical

Out-of-Pocket Cost?

Center Services?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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





Is authorization required?
Is a referral required for Outpatient Blood

Services?

No

No

No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

Yes

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Any Health-related Location

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 18

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health- One-way

related Location:

Select Mode of Transportation for Any Health- : Taxi

related Location: : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

Notes:

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

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SECTION B: #11A DME - BASE 1

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

SECTION B: #11A DME - BASE 2

Is there an enrollee Copayment?

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

Is authorization required? Yes

0% coinsurance for preferred brands and Notes:

manufacturers.

No

Yes

5% coinsurance for non preferred brands and

manufacturers.

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

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

Is there an enrollee Coinsurance?

Yes

Select which Prosthetics/Medical Supplies have : Medicare-covered Prosthetic Devices a Coinsurance (Select all that apply): : Medicare-covered Medical Supplies

Indicate Minimum Coinsurance percentage for 0% Medicare-covered Prosthetic Devices:

5% Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

0% Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for 5%

Medicare-covered Medical Supplies:

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

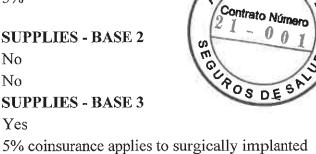
Is there an enrollee Deductible? No No Is there an enrollee Copayment?

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

Is authorization required? Yes

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

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





medical supplies non preferred brands and manufacturers.

0% coinsurance for Cardiovascular Devices.

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

Is there an enrollee Copayment? No

Do you limit Diabetic Supplies and Services to Yes

those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible? No

Is there an enrollee Copayment?

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with Yes

either the Chiropractor Services benefit or

Alternative Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment? No



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

SECTION B: #13A ACUPUNCTURE - BASE 3

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

SECTION B: #13B OTC ITEMS - BASE 1

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

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

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

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

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

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

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Mandatory

Yes

350.00

Every three months

No

No

Yes

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

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OTC or formulary drugs.

No No No No

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

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

50.00

amount:

Select Maximum Plan Benefit Coverage periodicity:

Other, Describe

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #13E OTHER 2 - BASE 2

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

Other, Describe

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

10.00

amount:

Select Maximum Plan Benefit Coverage periodicity:

No

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

SECTION B: #13F OTHER 3 - BASE 2

No

Is there an enrollee Coinsurance? 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 : I

Services Attestation

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

zero dollar cost sharing.

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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)*

Mandatory

Mandatory

Yes

: 14c9: Counseling Services : 14c17: Alternative Therapies*

Select type of benefit for Health Education: Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

No, indicate number

to, marcate namee

Individual Sessions

Mandatory

6

: Nursing Hotline

Mandatory

Yes



Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

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

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

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

Yes

Acupuncture benefit, or both?

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:



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

No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

No Is authorization required?

Is a referral required for Kidney Disease No

Education Services?

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

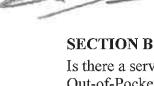
SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

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

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

Is there an enrollee Copayment? No

No Is authorization required for Medicare-covered



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

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

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?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Yes

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 Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?



Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

1

Select type of benefit for Fluoride Treatment:

Mandatory

Is this benefit unlimited for Fluoride Treatment?

No, indicate number

Indicate number of visits for Fluoride

1

Treatment:

Select the Fluoride Treatment periodicity:

Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays:

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

No

Services?

Notes:

Up to (1) Panoramic image or Intraoral

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

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images or Intraoral complete series, the

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

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

_

Yes

Select enhanced benefits:

: Non-routine Services : Diagnostic Services

: Restorative Services

Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics.

Yes

Other Oral/Maxillofacial Surgery, Other

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Nο

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?

Select enhanced benefit:

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

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service: Is this benefit unlimited for Other Service? Indicate quantity for Other Service: Yes

: Routine Eye Exams : Other

Mandatory

No, indicate number

1

Every year Eyewear eye exam Mandatory No, indicate number



Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

No Is authorization required? 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?

Select enhanced benefits:

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Every year

No

No

Mandatory

Yes

Mandatory

Yes

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:

Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames:

Is this benefit unlimited for Eyeglass frames?

Select type of benefit for Upgrades:

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Plan-specified amount per period

Yes



Indicate Combined Maximum Plan Benefit 200.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: **SECTION B: #17B EYEWEAR - BASE 4** No Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? SECTION B: #17B EYEWEAR - BASE 5 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #17B EYEWEAR - BASE 6 Is authorization required? No No Is a referral required for Evewear? SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid Mandatory Select type of benefit for Routine Hearing Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: Every year Select Routine Hearing Exams periodicity: Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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?

Select enhanced benefits: : Hearing Aids (all types)

Yes

Yes

Yes

1000.00

Every year

Mandatory

Both ears combined

Plan-specified amount per period

Select type of benefit for Hearing Aids (all

types):

Is this benefit unlimited for Hearing Aids (all

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage

ype:

Indicate Maximum Plan Benefit Coverage

amount:

Indicate Maximum Plan Benefit Coverage

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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 Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for No

the Chronically Ill?

Are you offering a VBID Hospice Benefit? Yes

Are you offering Part C benefits under the No

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

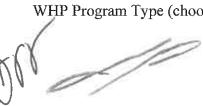
: Medicare Health Risk Assessment

: 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

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

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

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: Provider/Patient portals

Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

Engaged Annually:

363

No

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

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

reductions in cost?

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

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

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

No

No

selected to qualify?

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

notes.

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

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

No

deductible?

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

Are you offering retroactive reimbursement?

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No

Is there a maximum benefit amount?

No

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

Notes:

45 8

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



Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 15: PACKAGE #1

In-Home Support Services Notes:*

Benefit consists 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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Is there an enrollee Coinsurance?

Is there an enrollee Coinsurance?

Is there an enrollee Copayment? No Is there an enrollee Coinsurance? No

Is there an enrollee Copayment?

SECTION B: #19C VBID HOSPICE- BASE 2

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No

Is there an enrollee Copayment?

MM



SECTION B: #19C VBID HOSPICE- BASE 3

Mandatory supplemental benefits for enrollees

that elect hospice?

Enter the Maximum plan benefit amount:

Are hospice supplemental benefits contingent upon receiving services from an in-network

provider?

Coverage of primarily and non-primarily health

related items to ameliorate the

residence to discharge to.

functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.

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

Reduced cost sharing for unrelated medical care services received during hospice election

Other mandatory supplemental benefits

Describe other mandatory supplemental

benefits:

Yes

0.00

Yes

No

No

No

Yes

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-

3400.00

Pocket Cost Amount:





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

Yes

Medicare-covered plan services?

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

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:

24

: 10b2: Transportation Services - Any Healthrelated 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

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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?

Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?

SECTION D: NOTES

Notes:

Yes

No

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

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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?

Select the type of drug benefit:

Describe the components of your pharmacy network (select all that apply):

Sponsor attests that it will comply with 42 CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for over-the-counter medications (OTCs) under the utilization management program?

OTC Medication Attestation statement

Yes

Actuarially Equivalent Standard

: Standard/Preferred Retail

Out-of-Network

Standard Mail-Order

: Long-Term Care

: Sponsor attests that it will comply with 42 CFR 423.154.

Yes

No

Yes

Yes

No

Yes

Yes



: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

Yes

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

6



What is your Formulary Exception Tier?

Do you apply a second less expensive cost-

sharing level for all generic drugs approved for formulary exceptions?

No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan: Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the 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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier: : Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

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?

Are any of the drugs available at an extended

90

Yes

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

90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$28.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$28.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$19.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$14.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-IC

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 -

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one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

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Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

: Out-of-Network 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:

Enter number of days for Standard

90

30

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?

No

90

30

Yes

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

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- \$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 \$20.00

Pharmacy 1-month supply:

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 \$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Preferred Brand Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

: Brand Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

: Standard Retail/Preferred Retail Cost-Sharing -Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) one month supply

: Standard Retail/Preferred Retail Cost-Sharing that apply for this Tier:

three month supply

Out-of-Network Pharmacy - one month supply Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

Yes

No

SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 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 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31



Pharmacy 1-month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

\$47.00

\$94.00

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-\$84.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$1.57 \$1.40 Daily Preferred Retail Copayment Daily Copayment for Long-Term Care \$1.35

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-IC

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Brand Tier Drug type(s) (select all that apply): 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:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this

Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

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: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

Yes

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

\$100.00

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Pharmacy 1-month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

Select the type of drug benefit.

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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

Long Term Care Pharmacy - one month supply

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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:

Enter number of days for Standard

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?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

supply for the first fill?

90

30

Yes

Yes

90

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:

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:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

30

31

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard

25%

25%

Retail Cost-Sharing 3-month supply:

25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

25%

Mail-Order Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

25%

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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 -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

Contrato Número

0

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

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

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

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$6.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$12.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$2.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$4.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$4.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$6.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$2.00

Care Pharmacy 1-month supply:

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

\$0.06

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the

Medicare-defined Post Threshold Cost Shares

DMINISTRACIO

Contrato Número

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description

Preferred Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that

: Generic

apply):

Tier Includes:

Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

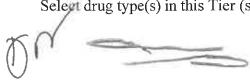
Tier Label Description

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

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 : Brand

apply):

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 : Brand

apply):

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 : Generic

apply): : 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 No

programs through the model?

SECTION RX: VBID - GENERAL

Does your VBID benefit include Part D No

reductions in cost?





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 Completed Section B3 Status Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Completed Section B7 Status 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

Section B18 Status

Completed
Section B19 Status

Completed
Section C Status

Completed
Section D Status

Completed
Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1



Organization Legal Name: Organization Marketing Name: Organization Web Site: Plan Name: Organization Type: Plan Type: Enrollee Type: Service Area(s): Service Area(s):

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Alcance (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranguitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR

40280 - Guayama, PR

40290 - Guayanilla, PR

40300 - Guaynabo, PR

40310 - Gurabo, PR

40320 - Hatillo, PR



Service Area(s):
Service Area(s):

Service Area(s)

40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR 40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR



	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	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

(877)207-8777

(877)207-8777

(888)620-1919

(888)620-1919

(877)207-8777

(877)207-8777



Customer Service Contact Local Phone Number

SECTION A: SECTION A-4

Customer Service Contact Phone Number for

Customer Service Contact Phone Number for

Customer Service Contact Local Phone Number

Customer Service Contact Local Phone Number

Prospective Medicare Beneficiaries:

for Prospective Medicare Beneficiaries:

Current Part D Medicare Beneficiaries:

for Current Part D Medicare Beneficiaries: Customer Service Contact Phone Number for

Prospective Part D Medicare Beneficiaries:

for Prospective Part D Medicare Beneficiaries:			
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520		
SECTION A: SECTION A-5			
Is your organization filing a standard bid for Section B of the PBP?	No		
Is your organization filing a standard bid for Section C of the PBP?	No		
SECTION A: SECTION A-6			
Is your organization filing a standard bid for Section D of the PBP?	No		
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1			
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes		
Select enhanced benefits:	Additional Days		



SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Select type of benefit for Additional Days:

Is this benefit unlimited for Additional Days?

3.7

Yes

Mandatory

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee

No

Is there an enrollee Coinsurance?

obtains care?

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?

Nο

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

What is your Inpatient Hospital-Acute benefit

Per Admission or Per Stay

period?

Do you charge cost sharing on the day of

No

discharge?

Is authorization required?

No

Is a referral required for Inpatient Hospital-

No

Acute Services?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee No

obtains care?

Is there an enrollee Coinsurance?

Nο

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric

Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of

No

discharge?

No

Is a referral required for Inpatient Psychiatric

No

Hospital Services?

Is authorization required?

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part

No

C?

Do you allow less than 3 day inpatient hospital

No

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee 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?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Per Admission or Per Stay

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for SNF Services? No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

No

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental

benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

No

No

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?

Notes: Services in the USA may also be available

through reimbursement in accordance with Medicare rates and the location where services

were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3





Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services

were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

amount:

75.00

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No Is there an enrollee Deductible? No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:

Worldwide services are covered through reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No Is authorization required? Yes No

Is a referral required for Partial Hospitalization?

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

No

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

No

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? 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 No

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1





Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Physician Specialist Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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 No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 4

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Dh =



Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2

No Is authorization required? Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? No

Is a referral required for Psychiatric Services? No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #71 PT AND SP SERVICES - BASE 2

Is authorization required? Yes Is a referral required for Physical Therapy and No

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Yes Do you offer an Additional Telehealth benefit

for Part B services?

: 7a: Primary Care Physician Services Select the Medicare-covered benefits that may have Additional Telehealth Benefits available: : 7d: Physician Specialist Services

7e1: Individual Sessions for Mental Health

Specialty Services

: 7h1: Individual Sessions for Psychiatric

Services

No

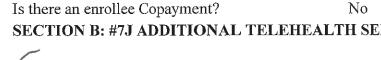
: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3









Is authorization required for Additional

Telehealth Services?

No

Yes

Is a referral required for Additional Telehealth

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required? No
Is a referral required for Opioid Treatment No

Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2



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SECTION B: #9B ASC SERVICES - BASE 2			
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SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee

Is a referral required for Ambulatory Surgical

No

No

Out-of-Pocket Cost?

Center Services?

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 No Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

No Is there an enrollee Deductible? Is there an enrollee Copayment? No



No Is authorization required? Is a referral required for Outpatient Blood No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Any Health-related Location

No

One-way

: Taxi

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 48

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-

related Location:

Select Mode of Transportation for Any Health-

related Location: : Van

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Transportation No

Services?

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?

Is there an enrollee Coinsurance? Yes

Indicate Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Maximum Coinsurance percentage for 5%

Medicare-covered Benefits:

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required? Yes

Notes: 0% coinsurance for preferred brands and

No

0%

Yes

No

0%

5%

5%

manufacturers.

5% coinsurance for non preferred brands and

: Medicare-covered Prosthetic Devices

: Medicare-covered Medical Supplies

manufacturers.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

Select which Prosthetics/Medical Supplies have

a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for 0%

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

Is there an enrollee Deductible?

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment? No

Do you limit Diabetic Supplies and Services to Yes

those from specified manufacturers?

Is authorization required? No

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

Is there an enrollee Copayment? 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 Yes

supplemental benefit under Part C?

: Number of Treatments Select enhanced benefit:

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is your Acupuncture benefit combined with Yes

either the Chiropractor Services benefit or

Alternative Therapies benefit, or both?

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?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT) Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Mandatory

Yes

50.00

Every three months

No

No

Yes

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

No No No

No



Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor.

JN

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

COVID-19 Food Allowance Enter name of Service (Optional):

Select type of benefit for Other 2: Mandatory

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage 50.00 amount:

Select Maximum Plan Benefit Coverage Other, Describe

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Benefit consists of a \$50 allowance for the Notes: 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

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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 Yes

Benefit Coverage amount?

SECTION B: #13F OTHER 3 - BASE 2

Indicate Maximum Plan Benefit Coverage 10.00

amount:

Select Maximum Plan Benefit Coverage Other, Describe periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No



Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Other Services?

No

Is a referral required for Other Services?

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 : I attest that there is no coinsurance, Services Attestation : opayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? No Is a referral required? No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical No

Exam as a supplemental benefit under Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Yes

Supplemental Benefits as a benefit under Part

C?

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)*

Mandatory

Mandatory

: 14c9: Counseling Services : 14c17: Alternative Therapies*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

No, indicate number

Individual Sessions

Mandatory

6

: Nursing Hotline

Mandatory

Yes



Indicate setting for Counseling Services:

Individual Sessions

Indicate duration of sessions (in minutes):

20

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

12

Therapies:

Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or

Yes

Acupuncture benefit, or both?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

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This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Remote Access Technologies (Nursing Hotline)

Notes:

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

The

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

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Pranic HealingMusic Therapy

• Hypnotherapy (for anxiety, phobias, substance

abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues)

• Naturopathic Medicine

• Traditional Chinese Medicine

Reflexology

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

Is authorization required?

Is a referral required for Kidney Disease No

Education Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

No

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required for Medicare-covered No

DW

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

No No

Is authorization required for Medicare-covered

Barium Enemas?

No

Is authorization required for Medicare-covered

Digital Rectal Exams?

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

No

Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes
Does the plan offer step therapy?

Yes

Does the benefit step from (select all that : Part B to Part B? apply): : Part B to Part D? : Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion 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

Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

: Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams?

No. indicate number

Indicate number of visits for Oral Exams: 1

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?



Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Select type of benefit for Fluoride Treatment:

Is this benefit unlimited for Fluoride Treatment?

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

1

No

No

Every six months

No, indicate number

No, indicate number

Mandatory

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity: Other, Describe

Is there a service-specific Maximum Plan

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required? No
Is a referral required for Preventive Dental No

Services?

Notes: Up to (1) Panoramic image or Intraoral

complete series including bitewings, every three years. Once the member has used the Panoramic

images or Intraoral complete series, the

radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2)

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: 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

is this benefit unfilmited for Nor

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory Yes

Is this benefit unlimited for Extractions?

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

1500.00

amount:

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,

AM

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.



Exams?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C? Select enhanced benefit:

Select type of benefit for Routine Eye Exams: Is this benefit unlimited for Routine Eye

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service: Is this benefit unlimited for Other Service? Indicate quantity for Other Service: Yes

: Routine Eye Exams : Other

Mandatory

No, indicate number

1

Every year
Eyewear eye exam
Mandatory
No, indicate number





Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? 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.

Every year

No

No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Evewear as a supplemental benefit under Part C?

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames:

Is this benefit unlimited for Eyeglass frames? Select type of benefit for Upgrades:

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Plan-specified amount per period

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Yes



Indicate Combined Maximum Plan Benefit 750.00 Coverage amount: Every year Select the Combined Maximum Plan Benefit Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #17B EYEWEAR - BASE 5 No Is there an enrollee Deductible? Is there an enrollee Copayment? No SECTION B: #17B EYEWEAR - BASE 6 Is authorization required? No Is a referral required for Eyewear? No SECTION B: #18A HEARING EXAMS - BASE 1 Yes Does the plan provide Hearing Exams as a supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #18A HEARING EXAMS - BASE 3**

No

No

No



Is a referral required for Hearing Exams?

Is authorization required?

Is there an enrollee Copayment?

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Yes

Yes

Yes

1000.00

No

No

Yes

Yes

Every year

Mandatory

Both ears combined

Plan-specified amount per period

Select type of benefit for Hearing Aids (all

types):

Is this benefit unlimited for Hearing Aids (all

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

amount:

Indicate Maximum Plan Benefit Coverage

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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?

Do you offer Special Supplemental Benefits for

the Chronically III?

Select what type of benefit your SSBCI : Additional Benefits

includes:

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the No

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Annual Wellness Visit

Contrato Número

DW

: 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

OMINISTRAC

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

Engaged Annually:

2718

No

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

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

Acute Stroke Other 2 Description:

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?

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

No

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

Benefit eligibility will be based on medical recommendation, and the following conditions:

- Post Inpatient stay 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

Yes

Supplemental Benefits as a benefit under Part

C?

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?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9: PACKAGE #1

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11: PACKAGE #1

Is there an enrollee Deductible?
Is there an enrollee Copayment?

No No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13: PACKAGE #1

Is authorization required?
Is a referral required for Other Defined

No No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15: PACKAGE #1

In-Home Support Services Notes:*



Benefit consists 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

SSBCI

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits

No

for this package?

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

No

deductible?

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-

: Other 1

Primarily Health Related Benefits for the

: Other 2

Chronically Ill includes:

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

Yes

Benefit Coverage amount?

375.00

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage

Every three months

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I OTHER 2 NON-PRIMARILY HEALTH RELATED BENEFIT - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

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.

Contrato Númiei

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance?

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?

Is there an enrollee Copayment?

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No





Mandatory supplemental benefits for enrollees that elect hospice?

Enter the Maximum plan benefit amount:

Are hospice supplemental benefits contingent upon receiving services from an in-network provider?

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.

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.

Reduced cost sharing for unrelated medical care services received during hospice election

Other mandatory supplemental benefits Describe other mandatory supplemental

benefits:

Yes

Yes

0.00

No

No

No

Yes

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.

Contrato Número

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

3400.00

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

: In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-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

No

Amount?

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

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

: Standard/Preferred Retail

Actuarially Equivalent Standard

: 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?

Nο Yes

Are there quantity limits on certain prescription

drugs?

Yes

Is prior authorization required for certain

prescription drugs?

No

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you implementing indication-based formulary

design)?

Do any drugs in your formulary require a step

therapy plan?

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.

Contrato Número

Yes

Do you offer OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6 What is your Formulary Exception Tier? 4 Do you apply a second less expensive cost-No

sharing level for all generic drugs approved for

formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable**

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Cost Share Tiers

Initial Coverage Limit (ICL) is reached?

SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Preferred Generic Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): 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 -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional): Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

90

Yes

30





tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

No

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$28.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$28.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$19.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$14.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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- : Standard Retail/Preferred Retail Cost-Sharing -

Sharing Pharmacy Location/supply amount(s) one month supply



that apply for this Tier:

Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Yes

No

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?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

Indicate Copayment amount for Preferred Retail

Indicate Copayment amount for Preferred Retail

\$40.00

Cost-Sharing 3-month supply:

\$15.00

Cost-Sharing 1-month supply:

\$30.00

Cost-Sharing 3-month supply:

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 \$20.00

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Pharmacy 1-month supply:

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 \$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier 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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

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?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

Yes

90

No

90

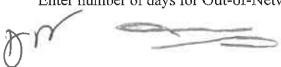
SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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 31

Pharmacy 1-month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

Indicate Copayment amount for Standard Retail \$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-\$84.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$1.57 Daily Preferred Retail Copayment \$1.40 Daily Copayment for Long-Term Care \$1.35

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard Tier 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 -

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

three month supply Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

Tier:

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

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?

Are any of the drugs available at an extended Yes

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

Contrato Número

POSDE

Yes

90

ICL

Indicate Copayment amount for Standard Retail \$100.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$190.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$95.00

Care Pharmacy 1-month supply:

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

Select the type of drug benefit:

Specialty Tier

Actuarially Equivalent Standard

Tier Includes:

Tier Drug type(s) (select all that apply):

Part D Drugs Only

: 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

month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

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:

Enter number of days for Standard

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?

day supply for this tier limited to a 1-month

Yes

30

90

Are any of the drugs available at an extended

supply for the first fill?

Yes

SECTION RX: TIER #5 - 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 #5 - 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

31

Pharmacy 1-month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing 3-month supply:

Contrato Número

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 3-month supply:

25%

25%

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail-Order Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

25%

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Select Care Drugs

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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 -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

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?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

supply for the first fill?

30

90

Yes

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:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

90

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$10.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$2.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$4.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$4.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$10.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$2.00

\$0.33

\$0.07

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment
Daily Preferred Retail Copayment

Daily Copayment for Long-Term Care \$0.06

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

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 : Brand

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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 : Brand

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Specialty Tier

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Generic : Brand apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Select Care Drugs Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Generic

: Brand apply):

Part D Drugs Only Tier Includes:

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?

SECTION RX: VBID - GENERAL

reductions in cost?

Does your VBID benefit include Part D

No

No





