MEDICARE PLATINO 2021

APPENDIX C (4) (21)

BID SUMMARY OF BENEFITS (SB)

Appendix C-4

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 024
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$50.00

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	7a: Primary Care Physician Services; 7d: Physician Specialist Services; 7e1: Individual Sessions for Mental Health Specialty Services; 7h1: Individual Sessions for Psychiatric Services; 14d: Kidney Disease Education Services; 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

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

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21-001

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 025
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Ultra (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

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

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comply

Question	Response
Does your VBID benefit include Part D reductions in cost?	No
How many packages does your Part D VBID benefit contain?	
Value Based Insurance Design Attestation	

Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.27
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$16.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$8.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$6.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.10
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$3.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives		
Question	Response	
Do you offer Part D Rewards and Incentives programs through the model?	No	

VBID - Part D Benefit Data

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

Part D Benefit Data				
Benefit	Plan Data		Benefit	Plan Data
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.10
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 024
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	Response
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$50.00

Tiered Cost sharing for Part B Services	
Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
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.

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

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Indicate Maximum Plan Benefit Coverage amount:	225.00
		Select Maximum Plan Benefit Coverage periodicity:	Every three months
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		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
		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
		Enter name of Service:	Transportation to Non-Health Related Destinations
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 2 Services?	No
		Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Is a referral required for Other Defined Supplemental Benefits?	No
		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).

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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 PBP.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Other 1; Other 2
		Enter name of Service:	Groceries and Cleaning Services Card
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	23925
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Open Heart Surgery
		Other 4 Description:	Hip Surgery
		Other 5 Description:	knee surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	850.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: [1]	$0.00
Indicate Minimum Copayment amount for Other Service: [1]	$0.00
Indicate Maximum Copayment amount for Other Service: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

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

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Non-routine Services: [1]	$0.00

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every six months
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Services?	No
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery Charge Payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 21-001

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care: 1	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care: 1	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices. 0% coinsurance for medical supplies preferred brands and manufacturers. 5% coinsurance for medical supplies non preferred brands and manufacturers.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: [1]	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: [1]	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: [1]	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: [1]	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-007

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years.

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

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

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 001

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

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: 1	$0.00
Indicate Maximum Copayment amount for Health Education: 1	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every two years
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 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.

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

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, Indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	1000.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	9496
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Open Heart Surgery
		Other 4 Description:	Hip Surgery
		Other 5 Description:	Knee Surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	Yes
		Select all the Non-Medicare-covered additional benefits that are exempt from the plan-level deductible:	14c: Other Defined Supplemental Benefits
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		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).

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Other 1; Other 2
		Enter name of Service:	Groceries and Cleaning Services Card

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 21 - 0 0 1

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	225.00
		Select Maximum Plan Benefit Coverage periodicity:	Every three months
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		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
		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
		Enter name of Service:	Transportation to Non-Health Related Destinations
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 2 Services?	No

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
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.

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

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 025
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Ultra (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Part D Benefit Data				
Benefit	**Plan Data**		**Benefit**	**Plan Data**
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.07
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90

Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.20
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$12.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.06
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives		
Question	Response	
Do you offer Part D Rewards and Incentives programs through the model?	No	

VBID - Part D Benefit Data		
Question	Response	
Does your VBID benefit include Part D reductions in cost?	No	
How many packages does your Part D VBID benefit contain?		

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Value Based Insurance Design Attestation	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comp

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 026
VBID: Yes - Part C
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

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

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	Yes
Select the benefits that have tiered cost sharing:	Medicare-covered
Select the Medicare-covered benefits that have tiered cost sharing:	7f: Podiatry Services

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No

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

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services; Routine Foot Care
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes
Notes:	$0 copay for services rendered in SALUS facility. $2 copay for Medicare covered services.

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Mental Health Specialty Services - Non-Physician?	No

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

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

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and non-surgically implanted prosthetic devices. 0% coinsurance for medical supplies preferred brands and manufacturers.10% coinsurance for medical supplies non preferred brands and manufacturers. 0% coinsurance for Cardiovascular Devices.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: [1]	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: [1]	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: [1]	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: [1]	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Services?	No
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: [1]	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: [1]	$0.00
Indicate Minimum Copayment amount for Counseling Services: [1]	$0.00
Indicate Maximum Copayment amount for Counseling Services: [1]	$0.00
Is authorization required?	No

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every six months
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Dental X-Rays:	Mandatory
Is this benefit unlimited for Dental X-Rays?	No, indicate number
Indicate number of visits for Dental X-Rays:	1
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 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.

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

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	100.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Eyewear?	No

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: 1	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 007

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
Value-Based Insurance Design Attestation	I attest that1) the benefits entered comply with CMS requirements for benefits offered in the VBID model test, 2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID model test, unless otherwise approved by CMS in writing, and 3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	1185
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Open Heart Surgery
		Other 4 Description:	Hip Surgery
		Other 5 Description:	Knee Surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		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).

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 2 Disease States: Other CMS-Approved Disease State			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Chronic Condition(s)
		Which disease states does this benefit apply? (Select all that apply):	Other CMS-Approved Disease State

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 2 Disease States: Other CMS-Approved Disease State			
PBP Section	**Category**	**Question**	**Response**
		Expected Number of Enrollees to be Targeted:	1263
		Expected Number of Enrollees to be engaged and receive Model benefits:	1263
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13d: Other 1
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		Notes:	Cash or Monetary Rebates
19b - 13d	Additional Benefits for VBID/UF/SSBCI - Other 1	Enter name of Service (Optional):	Cash or Monetary Rebates
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	160.00
		Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Services?	No
		Notes:	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.

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
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.

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001


ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 026
VBID: Yes - Part C
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Select the benefits that have tiered cost sharing:	Medicare-covered
Select the Medicare-covered benefits that have tiered cost sharing:	7f: Podiatry Services

Part D Benefit Data				
Benefit	**Plan Data**		**Benefit**	**Plan Data**
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.17
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$5.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
S 1 - 0 0 1

Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$10.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.33
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$10.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$20.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$10.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$10.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.16
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$5.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives	
Question	Response
Do you offer Part D Rewards and Incentives programs through the model?	No

VBID - Part D Benefit Data	
Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Does your VBID benefit include Part D reductions in cost?	No
How many packages does your Part D VBID benefit contain?	
Value Based Insurance Design Attestation	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comply

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comply

Question	Response
Does your VBID benefit include Part D reductions in cost?	No
How many packages does your Part D VBID benefit contain?	
Value Based Insurance Design Attestation	

Preferred Retail Cost-Sharing, 1 Month Copay	$10.00	$15.00	$42.00	$95.00		$2.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$20.00	$30.00	$84.00	$190.00		$4.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.50	$0.67	$1.57	$3.33		$0.27
Standard Retail Cost-Sharing, 1 Month Copay	$15.00	$20.00	$47.00	$100.00		$8.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$30.00	$40.00	$94.00	$200.00		$16.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$15.00	$20.00	$47.00	$100.00		$8.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$20.00	$30.00	$84.00	$190.00		$4.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.32	$0.48	$1.35	$3.06		$0.06
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$10.00	$15.00	$42.00	$95.00		$2.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives		
Question	Response	
Do you offer Part D Rewards and Incentives programs through the model?	No	

VBID - Part D Benefit Data

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

Part D Benefit Data				
Benefit	**Plan Data**		**Benefit**	**Plan Data**
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.33	$0.50	$1.40	$3.17		$0.07
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 028
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001


ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
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.

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		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).

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
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
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Open Heart Surgery
		Other 4 Description:	Hip Surgery
		Other 5 Description:	Knee Surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: [1]	$0.00
Indicate Minimum Copayment amount for Other Service: [1]	$0.00
Indicate Maximum Copayment amount for Other Service: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every six months
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 21 - 001

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Numero
21-001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Services?	No
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatologicals, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	40.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	20
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

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

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	7a: Primary Care Physician Services; 7d: Physician Specialist Services; 7e1: Individual Sessions for Mental Health Specialty Services; 7h1: Individual Sessions for Psychiatric Services; 14d: Kidney Disease Education Services; 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 028
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

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

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 032
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

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

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: 1	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: 1	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00

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

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

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: 1	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: 1	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	7a: Primary Care Physician Services; 7d: Physician Specialist Services; 7e1: Individual Sessions for Mental Health Specialty Services; 7h1: Individual Sessions for Psychiatric Services; 14d: Kidney Disease Education Services; 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	18
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	350.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatologicals, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
H 1 0 0 1

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Services?	No
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-007

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every six months
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	Yes
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	Yes
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Non-routine Services: [1]	$0.00

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 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.

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

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	200.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21-001

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	363
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Open Heart Surgery
		Other 4 Description:	Hip Surgery
		Other 5 Description:	Knee Surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		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).

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
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.

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


ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 032
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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

Tiered Cost sharing for Part B Services	
Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

Part D Benefit Data				
Benefit	**Plan Data**		**Benefit**	**Plan Data**
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.07
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.20
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$12.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$6.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.06
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives		
Question	Response	
Do you offer Part D Rewards and Incentives programs through the model?	No	

VBID - Part D Benefit Data

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

Question	Response
Does your VBID benefit include Part D reductions in cost?	No
How many packages does your Part D VBID benefit contain?	
Value Based Insurance Design Attestation	

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comply

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Bid Reports 2021

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 035
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Alcance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	**Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Go To Additional Reports for H5774 - 035: BPT Worksheet Report | Actuarial Certification History Report | Benefits Report | Part D Benefits Report | Notes Report | PBP Optional Supplemental Benefit Report | Out-of-Network, Point-of-Service, Visitor/Travel Benefits Report | Plan Level Cost Shares and Limits Report | Service Area Report

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$25.00

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services: [1]	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services: [1]	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services: [1]	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: [1]	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services: [1]	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

4a Emergency/Post-Stabilization Services Service Category Description Benefit Description	
Question	**Response**
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4b Urgently Needed Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

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

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

5 Partial Hospitalization Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Partial Hospitalization?	No

6 Home Health Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Home Health Services?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative Therapies benefit, or both?	No
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount per visit for Routine Care: [1]	$0.00
Indicate Maximum Copayment amount per visit for Routine Care: [1]	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

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

7d Physician Specialist Services excluding Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21-001

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

7j Additional Telehealth Services Service Category Description Benefit Description	
Question	**Response**
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	7a: Primary Care Physician Services; 7d: Physician Specialist Services; 7e1: Individual Sessions for Mental Health Specialty Services; 7h1: Individual Sessions for Psychiatric Services; 14d: Kidney Disease Education Services; 14e2: Diabetes Self-Management Training
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Services?	No
Is a referral required for Additional Telehealth Services?	Yes

7k Opioid Treatment Program Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

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

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

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

9c Outpatient Substance Abuse Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: [1]	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions: [1]	$0.00
Is authorization required?	No
Is a referral required for Outpatient Substance Abuse?	No

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	48
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Transportation Services?	No
Notes:	Other method of transportation is available in an automobile through a contracted provider.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes

ADMINISTRACIÓN
Contrato Número
21 - 001
SEGUROS DE SALUD

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies: 1	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: 1	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

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

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

ADMINISTRACIÓN 21
Contrato Número
21-001
SEGUROS DE SALUD

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	12
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative Therapies benefit, or both?	Yes
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No
Notes:	Services are subject to the combined maximum limit with Alternative therapy benefit.

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

13b OTC Items Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatological agents, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor. The Blood Pressure Monitor is covered up to one (1) every 5 years.

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

13e Other 2 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	COVID-19 Food Allowance
Select type of benefit for Other 2:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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
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.

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Enter name of Service (Optional):	Covid-19 Delivery charge payment
Select type of benefit for Other 3:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	10.00
Select Maximum Plan Benefit Coverage periodicity:	Other, Describe
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

13f Other 3 Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Services?	No
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.

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

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	6
Indicate setting for Nutritional/Dietary Benefit:	Individual Sessions
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Indicate setting for Counseling Services:	Individual Sessions
Indicate duration of sessions (in minutes):	20
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is your Alternative Therapies benefit combined with either the Chiropractor Services benefit or Acupuncture benefit, or both?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education: [1]	$0.00
Indicate Maximum Copayment amount for Health Education: [1]	$0.00

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit: 1	$0.00
Indicate Minimum Copayment amount for Counseling Services: 1	$0.00
Indicate Maximum Copayment amount for Counseling Services: 1	$0.00
Indicate Minimum Copayment amount for Alternative Therapies: 1	$0.00
Indicate Maximum Copayment amount for Alternative Therapies: 1	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction of qualified health professionals (health educators /Nutritionist) with you on specific disease conditions such as (but not limited to): hypertension, diabetes, congestive heart failure, and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management based on your health by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If you are sick, hurt or need health related advice, the nursing professionals will offer you guidance to help you decide whether you should make a doctor's appointment, visit an emergency room, or they will offer you self-care instructions to help alleviate your symptoms safely, in the comfort of your home.
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.

14c Eligible Supplemental Benefits as defined in Chapter 4 Service Category Description Benefit Description	
Question	**Response**
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21-001

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Oral Exams; Prophylaxis (Cleaning); Fluoride Treatment; Dental X-Rays
Select type of benefit for Oral Exams:	Mandatory
Is this benefit unlimited for Oral Exams?	No, indicate number
Indicate number of visits for Oral Exams:	1
Select the Oral Exams periodicity:	Every six months
Select type of benefit for Prophylaxis (Cleaning):	Mandatory
Is this benefit unlimited for Prophylaxis (Cleaning)?	No, indicate number
Indicate number of visits for Prophylaxis (Cleaning):	1
Select the Prophylaxis (Cleaning) periodicity:	Every six months
Select type of benefit for Fluoride Treatment:	Mandatory
Is this benefit unlimited for Fluoride Treatment?	No, indicate number
Indicate number of visits for Fluoride Treatment:	1
Select the Fluoride Treatment periodicity:	Every six months
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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Select the Dental X-Rays periodicity:	Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Oral Exams: 1	$0.00
Indicate Maximum Copayment amount for Oral Exams: 1	$0.00
Indicate Minimum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Maximum Copayment amount for Prophylaxis (Cleaning): 1	$0.00
Indicate Minimum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Maximum Copayment amount for Fluoride Treatment: 1	$0.00
Indicate Minimum Copayment amount for Dental X-Rays: 1	$0.00
Indicate Maximum Copayment amount for Dental X-Rays: 1	$0.00
Is authorization required?	No
Is a referral required for Preventive Dental Services?	No
Notes:	Up to (1) Panoramic image or Intraoral complete series including bitewings, every three years. Once the member has used the Panoramic images or Intraoral complete series, the radiographic images limit has been reached for those 3 years. Up to (6) radiographic images include up to (4) periapicals and up to (2) bitewings images per year.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
21-001

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Notes:	Restorative: Amalgams and Composites Resin restorations-every 24 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.

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

17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Enter name of Other Service:	Eyewear eye exam
Select type of benefit for Other Service:	Mandatory
Is this benefit unlimited for Other Service?	No, indicate number
Indicate quantity for Other Service:	1
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: 1	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams: 1	$0.00
Indicate Minimum Copayment amount for Other Service: 1	$0.00
Indicate Maximum Copayment amount for Other Service: 1	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	The routine eye exam is the test performed by the physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	750.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits: [1]	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams: [1]	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: [1]	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	Yes
Select what type of benefit your SSBCI includes:	Additional Benefits
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

19a Reduced Cost Sharing for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	2718
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI Service Category Description Benefit Description	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	2

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 1 Description:	Oncology patients with active chemo by infusion
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Hip Surgery
		Other 4 Description:	Knee Surgery
		Other 5 Description:	Open Heart Surgery
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 21 - 007

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c: Other Defined Supplemental Benefits
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Eligible Supplemental Benefits as defined in Chapter 4	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		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).

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	SSBCI
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13i-O: Non-Primarily Health Related Benefits for the Chronically Ill (Other)
		Are any benefits exempt from the plan-level deductible?	No
		Are you offering retroactive reimbursement?	No
		Is there a maximum benefit amount?	No
		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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Other 1; Other 2
		Enter name of Service:	Groceries and cleaning services card
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	375.00

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5			
PBP Section	**Category**	**Question**	**Response**
		Select Maximum Plan Benefit Coverage periodicity:	Every three months
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 1 Services?	No
		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
		Enter name of Service:	Transportation to Non-Health Related Destinations
		Select type of benefit for Other 2:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 2 Services?	No
		Notes:	SSBCI eligible members will have the flexibility of using the transportation benefit trips described in section 10B for non-health related locations.

19c VBID Hospice Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
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?	Yes
Enter the Maximum plan benefit amount:	0.00
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
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.

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

Bid Reports 2021

Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 035
VBID: ERROR
MA Uniformity Flexibility: Yes
Special Supplemental Benefits for the Chronically Ill: Yes
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Alcance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 7 - Renewal-Plan Successfully Uploaded (06/01/20)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00021585
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**
MA Rebates Used to Reduce Part B Premium:	Yes
Part B Premium Reduction Amount:	$25.00

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21 - 001

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

Part D Benefit Data				
Benefit	**Plan Data**		**Benefit**	**Plan Data**
Deductible	445		Pre-ICL Cost Shares	See below
Initial Coverage Limit	4130		Enrollee Out-of-Pocket Cost Threshold	$6,550.00/Every year
OON cost sharing structure	Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable		Quantity Limits	Yes
Prior Authorization Required	Yes		Step Therapy Plan	Yes
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes		OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	Yes		Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Utilizes floor pricing	Yes		Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No		Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.		Does plan utilize ceiling pricing?	No
Cost Shares Above the Threshold	The greater of $3.70 for generic or a preferred multi-source drug and $9.20 for all other drugs, or 5%		Are you implementing indication-based formulary design?	No

Pre-Initial Coverage Limit						
	Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 5**	**Tier 6**
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.47	$0.50	$1.40	$3.17		$0.07
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
21-001

Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.33
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$10.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$20.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$10.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$28.00	$30.00	$84.00	$190.00		$4.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.45	$0.48	$1.35	$3.06		$0.06
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$14.00	$15.00	$42.00	$95.00		$2.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	

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

VBID - Part D Rewards and Incentives	
Question	Response
Do you offer Part D Rewards and Incentives programs through the model?	No

VBID - Part D Benefit Data	
Question	Response
Does your VBID benefit include Part D reductions in cost?	No

How many packages does your Part D VBID benefit contain?	
Value Based Insurance Design Attestation	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE AND MEDICAID INNOVATION

DATE: May 20, 2020

TO: Vanessa Acevedo Cabán
Triple-S Management Corporation
1484 Av. Franklin Delano Roosevelt
San Juan, Puerto Rico 00920

FROM: Laura McWright, Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

Subject: Medicare Advantage Value-Based Insurance Design Model Application – Calendar Year 2021

Thank you for your application to the Centers for Medicare & Medicaid Services (CMS) Medicare Advantage Value-Based Insurance Design (VBID) Model, on behalf of Triple-S Management Corporation.

We have determined, on a provisional basis that the plan benefit packages (PBPs) and specific VBID model components referenced in your updated application meet the Model's requirements and thus make your organization eligible to participate in the VBID Model. Accordingly, your organization is authorized to submit a calendar year (CY) 2021 Medicare Advantage (MA) or MA prescription drug (MA-PD) bid submission that contains VBID benefits offered under authority of the VBID Model for the contract(s) and PBP(s) listed on page 3.

This authorization should not be construed as final approval by CMS of the VBID Model benefits described in your application or final confirmation that your organization is eligible to participate in the VBID Model for CY 2021. Your acceptance into the VBID Model for CY 2021 will become final upon full execution of the CY 2021 MA contract which includes an addendum for participation in the Model. Until such time, CMS reserves the right to revoke this preliminary determination.

This authorization extends only to the specific VBID Model benefits, and for the specific PBPs proposed in your application. Those PBPs are listed at the end of this memo. If CMS has granted your organization an exception from one or more Model eligibility requirements, the contingencies and caveats of that exception continue to apply. This authorization should not be construed as approval or disapproval of any other element of your MA or MA-PD product offering, including marketing and communications plans for VBID Model benefits, which may have been described in the application.

Please follow instructions to be issued by CMS and the Office of the Actuary for the proper inclusion of VBID Model benefits in your CY 2021 bid submission and submission of supplemental formulary files, if any. All bids submitted must 1) comply

with CMS requirements for benefits offered in the VBID model; 2) be consistent with the benefit proposals and the actuarial or financial information contained in your application, as modified or clarified in subsequent written communication with CMS prior to this notice, unless otherwise approved by CMS in writing; and 3) not be structured to discriminate against any Medicare beneficiary.

Should you wish to withdraw your application for one or more PBPs, please notify the VBID Model team in writing at VBID@cms.hhs.gov.

You may also request to make changes to the approved interventions or financial projections contained in your application by contacting CMS at the same address. Prior to bid submission, CMS will allow incremental changes to proposed interventions, but only where good cause is shown. After bid submission, CMS will only allow changes of a type typically allowed for MA and Part D benefits after bid submission, such as those required in response to CMS bid desk review findings, or made during rebate reallocation. Allowance of changes to approved VBID Model components is a matter of CMS discretion, and CMS may require resubmission of actuarial documentation to account for proposed changes.

A condition of this authorization is that you obtain prior approval from CMS for the publication or release of any press release, external report or statistical/analytical material or other similar material that references your participation in the VBID Model. External reports and statistical/analytical material may include papers, articles, professional publications, speeches, and testimony. The CMS will make reasonable efforts to complete its review expeditiously. Any material submitted to CMS for prior approval that is not disapproved in writing by the CMS within 30 calendar days after receipt by CMS will be deemed approved. You must also include the following statement on the first page of all external reports and statistical/analytical material that are subject to this paragraph: "The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of the CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document." This condition will remain until the signing of the CY 2021 MA contract, whose terms will govern this subject.

We appreciate your interest in the VBID Model and look forward to your participation. Please continue to adhere to the terms of the VBID Model's Request for Applications, and monitor communications from the CMS for additional guidance to VBID Model participants.

Sincerely,

Laura McWright
Deputy Director, Seamless Care Models Group, Center for Medicare and Medicaid Innovation

The below contract(s) and PBP(s) for Triple-S Management Corporation are provisionally approved for participation in the VBID Model for Contract Year 2021:

H4005-001-000
H4005-004-000
H5774-003-000
H5774-005-000
H5774-023-000
H5774-027-000
H5774-031-000
H5774-033-000
H5774-022-000
H5774-024-000
H5774-025-000
H5774-026-000
H5774-028-000
H5774-032-000