## MEDICARE PLATINO CONTRACT



**APPENDIX C (1) (22)** 

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)

The



## TRIPLE-S ADVANTAGE, INC.

# APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5774-024



Page 1 of 45 PBP Data Report

#### PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 024, SEGMENT 0

PBP Module: Requested By: m660

#### PLAN SYSTEM INFORMATION

Last entry Date: 06/06/2021 PBP Software Version: 2022.01

06/06/2021 02:11:22 PM SA Western Standard Plan Ready for Upload Timestamp:

Time

06/08/2021 01:15:56 AM SA Western Standard MA BPT Timestamp:

Time

06/08/2021 01:15:57 AM SA Western Standard PD BPT Timestamp:

Time

Last Upload File Creation Timestamp: 06/08/2021 01:18:05 AM SA Western Standard

Time

06/08/2021 #02424 **Upload Status:** 

#### **PLAN STATUS**

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Section B3 Status Completed Section B4 Status Completed Section B5 Status Section B6 Status

Section B7 Status Section B8 Status

DMINISTRACION Section B9 Status

Section B10 Status Contrato Número Section B11 Status

Completed Section B12 Status

Section B13 Status Completed

Section B14 Status

Section B15 Status Section B16 Status Completed

Section B17 Status

Section B18 Status Section B19 Status Completed

Section C Status

Section D Status Section Mrx Status

SECTION A: SECTION A-1

Completed Completed

Completed Completed Completed

Completed Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed

Completed



6/8/2021 ahaut.hlank

PBP Data Report Page 2 of 45

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

-1. ---.1.1 --.1.

Service Area(s):

Page 3 of 45 PBP Data Report

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

Service Area(s):



40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR

40360 - Jayuya, PR

40370 - Juana Diaz, PR

40380 - Juncos, PR

40390 - Lajas, PR

40400 - Lares, PR

40410 - Las Marias, PR

40420 - Las Piedras, PR

40430 - Loiza, PR

40440 - Luquillo, PR

40450 - Manati, PR

40460 - Maricao, PR

40470 - Maunabo, PR

40480 - Mayaguez, PR

40490 - Moca, PR

40500 - Morovis, PR

40510 - Naguabo, PR

40520 - Naranjito, PR

40530 - Orocovis, PR

40540 - Patillas, PR

40550 - Penuelas, PR

40560 - Ponce, PR

40570 - Quebradillas, PR

40580 - Rincon, PR

40590 - Rio Grande, PR

40610 - Sabana Grande, PR

40620 - Salinas, PR

40630 - San German, PR

40640 - San Juan, PR

40650 - San Lorenzo, PR

40660 - San Sebastian, PR

40670 - Santa Isabel, PR

40680 - Toa Alta, PR

40690 - Toa Baja, PR

40700 - Trujillo Alto, PR

40710 - Utuado, PR

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR





6/8/2021 ahantihlank

PBP Data Report Page 4 of 45

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	024
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2022 total projected member months for this plan:	328296
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes KOMINISTRACION
Is this a Special Needs Plan?	Yes Contrato Name
Special Needs Plan Type:	Dual-Eligible 42
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	No No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)221-2234
SECTION A: SECTION A-4	•
Customer Service Contact Local Phone Number	(833)221-2234

shout-blook

Page 5 of 45

	for Prospective Part D Medicare Beneficiaries:		
	Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
	Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520	
	SECTION A: SECTION A-5		
	Is your organization filing a standard bid for Section B of the PBP?	No	
	Is your organization filing a standard bid for Section C of the PBP?	No	
	SECTION A: SECTION A-6		
	Is your organization filing a standard bid for Section D of the PBP?	No	
	Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No	
	SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1		
	Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes	
	Select enhanced benefits:	: Additional Days	
	Select type of benefit for Additional Days:	Mandatory	
	Is this benefit unlimited for Additional Days?	Yes	
	SECTION B: #1A INPATIENT HOSPITAL-AC	UTE - BASE 2	
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
	Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No	
	Is there an enrollee Coinsurance?	No	
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5			
	Does this plan's Additional Days cost sharing	No	







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

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

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

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

period?

Do you charge cost sharing on the day of No

discharge?

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

Acute Services?

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

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost No

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay

benefit period?

Do you charge cost sharing on the day of No

discharge?

Is authorization required?

Is a referral required for Inpatient Psychiatric No

Hospital Services?

**SECTION B: #2 SNF - BASE 1** 

Does the plan provide Skilled Nursing Facility No

Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital No

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

**SECTION B: #2 SNF - BASE 2** 





ahout-blank 6/8/2021

Page 7 of 45 PBP Data Report

No

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance? No

**SECTION B: #2 SNF - BASE 6** 

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of No

discharge?

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

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

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

Yes Is authorization required? No

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

No Is there an enrollee Copayment?

Services in the USA may also be available Notes:

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

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

6/8/2021 ahout-blank

PBP Data Report Page 8 of 45

Notes: Services in the USA may also be available

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

were provided.

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

Does the plan provide Worldwide Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency Mandatory

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

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

Coverage?

Is the service-specific Maximum Plan Benefit No

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 75.00

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

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

Notes: Worldwide services are covered through

reimbursement in accordance with Triple-S

Advantage rates.

**SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

**SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2** 

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

**SECTION B: #6 HOME HEALTH SERVICES - BASE 1** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #6 HOME HEALTH SERVICES - BASE 2** 

6/8/2021

about-blank

Page 9 of 45

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

**SECTION B: #6 HOME HEALTH SERVICES - BASE 3** 

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?



Page 10 of 45 PBP Data Report

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

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Mandatory Select type of benefit for Routine Foot Care:

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

Every year Select the Routine Foot Care periodicity:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

**SECTION B: #7F PODIATRY SERVICES - BASE 2** 

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

No Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

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



PBP Data Report Page 11 of 45

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

**SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3** 

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may 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

No

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

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

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth Yes





about-hlank 6/8/2021

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

Is a referral required for Opioid Treatment

**Program Services?** 

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

No

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

Is authorization required?

Yes

Is a referral required for Outpatient Diagnostic

No

Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?

1100000105, 1050 E40 501 11005.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

Is authorization required? Yes

Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required for Medicare-covered Yes

Page 13 of 45

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #9B ASC SERVICES - BASE 2** 

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

No

Center Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?





about-blank 6/8/2021

PBP Data Report Page 14 of 45

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

**SECTION B: #10A AMBULANCE SERVICES - BASE 3** 

Is authorization required for non-emergency Yes

Medicare services?

Select enhanced benefit:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Any Health-related Location

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for

Any Health-related Location?

No

24

Yes

Indicate number of trips for Any Health-related

Location:

Every year

Select Any Health-related Location Trips

periodicity:

Select Type of Transportation for Any Health-

related Location:

One-way

Select Mode of Transportation for Any Health-

related Location:

: Taxi : Van

No

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

Notes: Other methods of transportation are available,

such as an automobile through a contracted

provider.

**SECTION B: #11A DME - BASE 1** 

Is there a service-specific Maximum Enrollee No



Page 15 of 45

Out-of-Pocket Cost?			
Is there an enrollee Coinsurance?	Yes		
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%		
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%		
Is there an enrollee Deductible?	No		
Is there an enrollee Copayment?	No		
SECTION B: #11A DME - BASE 2			
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes		
Is authorization required?	Yes		
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.		
SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1			
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No		
Is there an enrollee Coinsurance?	Yes		
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	: Medicare-covered Prosthetic Devices : Medicare-covered Medical Supplies		
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	: Medicare-covered Medical Supplies  0%  **DMINISTRACTOR  5%		
Indicate Maximum Coinsurance percentage for	5% ( 2 2 Nition ) Z		

Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

PBP Data Report

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

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

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

Is authorization required? Yes

Notes: 5% coinsurance applies to surgically implanted

0%

5%

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 preferred brand medical

supplies and manufacturers.

5% coinsurance for non-preferred brand medical

supplies and manufacturers.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required?

**SECTION B: #12 DIALYSIS SERVICES - BASE 1** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

**SECTION B: #12 DIALYSIS SERVICES - BASE 2** 

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

**SECTION B: #13A ACUPUNCTURE - BASE 2** 

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13A ACUPUNCTURE - BASE 3

Notes: Services are subject to the combined maximum

limit with Alternative therapy benefit.

SECTION B: #13B OTC ITEMS - BASE 1







MINISTRA

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

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

**SECTION B: #13B OTC ITEMS - BASE 2** 

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

**SECTION B: #13B OTC ITEMS - BASE 3** 

Notes:

Yes

Mandatory

Yes

75.00

Every three months

No

No

Yes

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

OTC or formulary drugs.

No

No

No

No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy,

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.

Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

**SECTION B: #13C MEAL BENEFIT - BASE 1** 

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



shout-blank 6/8/2021

PBP Data Report Page 18 of 45

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

Medicare-covered Zero Dollar Preventive : I a

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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

114c2: Nutritional/Dietary Benefit

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

Hotline)\*

Yes

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

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

Benefit:

No, indicate number

Benefit?
Indicate number of visits for Nutritional/Dietary

Is this benefit unlimited for Nutritional/Dietary

Benefit:

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

wiandatory

4

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

Indicate setting for Counseling Services:

Services?

Yes

Individual Sessions

Indicate duration of sessions (in minutes): 20

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative

Thornios?

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

12

about-blank 6/8/2021

PBP Data Report Page 19 of 45

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

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

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

Is authorization required?

Is a referral required for Other Defined Supplemental Benefits?

Health Education Notes:

This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management by health educators.

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

Remote Access Technologies (Nursing Hotline) Notes:

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



6/8/2021

shoutshlonk

Page 20 of 45 PBP Data Report

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:\*

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

Therapies include:

Chinese Medicine

• Pranic Healing

Music Therapy

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

Naturopathic Medicine

• Traditional Chinese Medicine

Reflexology

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

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

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

**Education Services?** 

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

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

Glaucoma Screening?

Is authorization required for Medicare-covered No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?



Is a referral required for any Services?

No

No





PBP Data Report Page 21 of 45

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

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B?

Part B to Part D?

Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion Yes

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

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

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams?

No, indicate number

Indicate number of visits for Oral Exams: 1

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

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

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

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

Indicate number of visits for Dental X-Rays: 1

Select the Dental X-Rays periodicity: Other, Describe



PBP Data Report Page 22 of 45

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

Is a referral required for Preventive Dental

Services?

Notes: Up to (1) panoramic image or intraoral complete

No

Yes

series including bitewings, every (3) 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, including up to (4) periapical and up to (2)

bitewings images per year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits:

: Non-routine Services

Diagnostic Services
Restorative Services

: Endodontics : Periodontics

: Extractions

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine Yes

Services?

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic Yes

Services?

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory



Page 23 of 45 PBP Data Report

Is this benefit unlimited for Periodontics? Yes

Mandatory Select type of benefit for Extractions:

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Mandatory

Yes

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

amount:

3000.00

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes Is a referral required for Comprehensive Dental No

Services?

Notes:

Services are administered with the periodicity established by the American Dental Association

(ADA). Diagnostic services are not deducted from the annual maximum benefit limit and are administered with the periodicity established by

the American Dental Association (ADA).

#### SECTION B: #17A EYE EXAMS - BASE 1

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

: Routine Eye Exams Select enhanced benefit:

: Other

Yes

Select type of benefit for Routine Eye Exams: Mandatory

Is this benefit unlimited for Routine Eye

Exams?

No, indicate number

Exams:

ahout-hlank

Every year

1

Indicate number of exams for Routine Eye

Select the Routine Eye Exams periodicity:

6/8/2021



Page 24 of 45 PBP Data Report

Enter name of Other Service: Evewear 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:

Select the Other Service periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

**SECTION B: #17A EYE EXAMS - BASE 3** 

Is authorization required? No

Is a referral required for Eye Exams? No

Routine eye exam: Test performed by physician Notes:

to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eve exam, consultation and prescription for eyewear

including refraction.

**SECTION B: #17B EYEWEAR - BASE 1** 

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

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames) : Eveglass lenses

: Eyeglass frames

: Upgrades

Yes

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and Mandatory frames):

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

**SECTION B: #17B EYEWEAR - BASE 2** 

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

Mandatory Select type of benefit for Eyeglass frames:

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

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

6/8/2021 ahout-blank

PBP Data Report Page 25 of 45

Plan-specified amount per period Select the Maximum Plan Benefit Coverage type: Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 850.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: **SECTION B: #17B EYEWEAR - BASE 4** No Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #17B EYEWEAR - BASE 5 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #17B EYEWEAR - BASE 6 Is authorization required? No No Is a referral required for Eyewear? SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams : Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number ITI for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Every year Select Fitting/Evaluation for Hearing Aid periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No

about:blank 6/8/2021

No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

PBP Data Report Page 26 of 45

**SECTION B: #18A HEARING EXAMS - BASE 3** 

Is there an enrollee Copayment?

Is authorization required?

No

Is a referral required for Hearing Exams?

No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all Mandatory

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

**SECTION B: #18B HEARING AIDS - BASE 2** 

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Both ears combined

Amount apply per ear or for both ears

combined?

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

type

Indicate Maximum Plan Benefit Coverage 2000.00

amount:

Indicate Maximum Plan Benefit Coverage Every year

periodicity:

**SECTION B: #18B HEARING AIDS - BASE 3** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #18B HEARING AIDS - BASE 4** 

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for No

the Chronically Ill?

Are you offering a VBID Hospice Benefit?

Yes

Are you offering Part C benefits under the

Yes

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

Contrato Nacionario III



about:blank 6/8/2021

Page 27 of 45 PBP Data Report

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition

or Socioeconomic Status : Cash or Monetary Rebates

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person : Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

No

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

MINISTRA

SDES

Records

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

**Engaged Annually:** 

23226

#### SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or Monetary Rebates: : Debit Card/Check

75.00 Cash or Monetary Rebates amount per month: Maximum Annual Cash or Monetary Rebates 900.00

available:

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

No

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

3

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

PACKAGE #1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility

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

6/8/2021 about:blank

PBP Data Report Page 28 of 45

#### PACKAGE #1

Which disease states does this benefit apply? : Chronic Obstructive Pulmonary Disease

(Select all that apply): (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 or systemic radiotherapy

Other 2 Description: Acute Stroke

Other 3 Description: Hip, knee or open heart surgery

Other 4 Description: COPD patients with supplemental oxigen

dependency

Other 5 Description: Bedridden patients

Does the enrollee need to have all diseases No

selected to qualify?

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in

notes.

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

No

Is there a prerequisite for any additional benefits No

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level No

deductible?

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

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

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

Notes:



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

- Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home
- Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home
- Post Inpatient stay for Acute Stroke with transition of care to patient's home
- Oncology Patients with Active Chemo by

about:blank 6/8/2021



Infusion or systemic radiotherapy

- Patients discharged from open heart surgery, hip surgery or knee surgery with transition of care to patient's home

- COPD patients with supplemental oxygen dependency

- Bedridden patients

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

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

Select type of benefit for In-Home Support

Mandatory

Services:

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

#### SECTION B: VBID/UF/SSBC SECTIO

Contrato Número

BASE 16: PACKAGE #1

In-Home Support Services No es

Benefit consists of In-home Support for ctivities of daily living such as: Help with athing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry,

M

6/8/2021

PBP Data Report Page 30 of 45

dishes), meal preparation, and 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, (4) hours per day for a maximum of (12) days in the calendar year.

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

Targeting Methodology - Please choose one or

both:

: Socioeconomic Status

Select LIS reduction level: : Dual-Eligible Status (for territories)

Expected Number of Enrollees to be Targeted: 23226 Expected Number of Enrollees to be engaged 23226

and receive Model benefits:

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

Is there a prerequisite for any additional benefits

Select all the Non-Medicare-covered additional

for this package?

: 10b: Transportation Services

benefits offered in this package:

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

Are any benefits exempt from the plan-level

No

No

deductible?

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

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

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

Notes: Benefit consists of adding non-medical

destinations (church, supermarket, banks [financial institutions]) to the transportation benefit in section B #10b. This will not

duplicate or add additional trips.

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 1: PACKAGE #2

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

74

POSDES

about:blank 6/8/2021

Page 31 of 45

Is this benefit unlimited for number of trips for

Any Health-related Location?

No

Indicate number of trips for Any Health-related

Location:

24

Select Any Health-related Location Trips

periodicity:

Every year

Select Type of Transportation for Any Health-

related Location:

One-way

Select Mode of Transportation for Any Health-

related Location:

: Taxi : Van

: Other, Describe

SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES - BASE 2:

PACKAGE #2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

PACKAGE #2

No

No

Is there an enrollee Coinsurance? No

No Is there an enrollee Deductible? SECTION B: VBID/UF/SSBCI 19B #10B TRANSPORTATION SERVICES

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

Services?

Amount of trips is combined (not duplicated) Notes:

with the 10b trips for non-health related locations. Eligible members will have the flexibility of using transportation services to other locations such as churches, supermarkets

and financial institutions (i.e., banks).

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #3

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #3

Which disease states does this benefit apply?

: Other 1

(Select all that apply):

Other 1 Description:

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

INFO): PACKAGE #3

Is there a prerequisite for any additional benefits

for this package?

: 14c: Other Defined Supplemental Benefits Select all the Non-Medicare-covered additional

6/8/2021 about:blank

No

Bedridden patients with specific essential services requirements

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes:

Benefit is limited to bedridden patients with essential services requirements limited to

- -Chemotherapy
- -Oxygen dependency
- -Ventilator
- -Enteral Nutrition
- -Specialty drugs (cancer/pulmonary

hypertension)

- -CPAP
- -Wound Care
- -Ostomized

Besides having the eligible condition, member must meet with care manager at least once every quarter in order to have access to the benefit.

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

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

BASE 3: PACKAGE #3

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #3

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #3

DAGE 7. I ACKAGE 113

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #3

Is there an enrollee Coinsurance?

No

ahout-blank 6/8/2021

Page 33 of 45 PBP Data Report

#### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 12: PACKAGE #3

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

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

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

Supplemental Benefits?

#### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #3

In-Home Support Services Notes:\*



After meeting with the care manager once every quarter, the benefit will be available in blocks of 40 hours per quarter (not cumulative) for a maximum of 160 hours per year. Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, medication reminders, noninvasive / non-clinical care such as diaper change or patient rotation to avoid ulcers, documentation and reporting back to the plan, coordinate doctor visits, plan coverage navigation to order refills and coordinate delivery using technology and escalation process to attend particular needs. 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.

#### SECTION B: #19C VBID HOSPICE- BASE 1

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

#### **SECTION B: #19C VBID HOSPICE- BASE 2**

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

#### **SECTION B: #19C VBID HOSPICE- BASE 3**

Are you offering hospice supplemental benefits? Yes Is there a max plan benefit amount? No Are hospice supplemental benefits contingent Yes upon receiving services from an in-network

Coverage of primarily and non-primarily health related items to ameliorate the

provider?

No

6/8/2021 about:blank

PBP Data Report Page 34 of 45

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

Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.

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

Other mandatory supplemental benefits Describe other mandatory supplemental

benefits:

#### **SECTION B: #19C VBID HOSPICE- BASE 4**

Hospice notes



No

No

Yes

In-Home Support

In-Home Support Benefit consisting of assistance by qualified staff for activities of daily living, such as help with bathing and dressing, transfer or assistance for mobility, light housekeeping (cleaning, laundry, dishes), meal preparation and medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider. There is no cost-sharing or copayment for drugs and biologicals or inpatient respite care for both innetwork and out-of-network hospice benefits.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

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

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

: In-Network Medicare-covered benefits

Yes

Yes

Voluntary

3400.00

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL

194

about:blank 6/8/2021

Page 35 of 45 PBP Data Report

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

: Standard/Preferred Retail

: Out-of-Network : Standard Mail-Order

: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42

CFR 423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing? Do you pay for over-the-counter medications

(OTCs) under the utilization management program?

Yes

No

Yes

OTC Medication Attestation statement

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

**SECTION RX: MEDICARE RX GENERAL 3** 

Indicate number of Tiers in your Part D benefit:

What is your Formulary Exceptions Tier?

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

formulary exceptions?

6 4

No

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to

select):

Preferred Generic, To The Ferred Brand, Non-Preferred Brand, Specialty Tier, Select Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) cost-

sharing structure for this plan:

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

the Standard Retail allowable\*\*

SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

Cost Share Tiers

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

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

6/8/2021 about:blank

Generic Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

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

that apply for this Tier:

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

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

: Out-of-Network Pharmacy - one month supply

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

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

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

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

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

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

month supply:

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

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

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

Yes

No



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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

31 Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$19.00 Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$38.00 Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00 Cost-Sharing 1-month supply:

\$28.00 Indicate Copayment amount for Preferred Retail

Cost-Sharing 3-month supply:



PBP Data Report Page 37 of 45

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

Indicate Copayment amount for Standard Mail-

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$14.00

\$28.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

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

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

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

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

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

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

Select all Long-Term Care Pharmacy

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

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

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

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

supply for the first fill?

30

90

Yes

No



about:blank 6/8/2021

POSDESP

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

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

90

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

\$20.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

\$30.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$15.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Tier Label Description Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

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

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

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

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Out-of-Network Pharmacy - one month supply

6/8/2021 about:blank

Page 39 of 45 PBP Data Report

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

: Standard Mail Order Cost-Sharing - three

: Long Term Care Pharmacy - one month supply

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

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

Yes

No

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

supply for the first fill?

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

31

Indicate Copayment amount for Standard Retail \$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$84.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

about:blank

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

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

6/8/2021

Page 40 of 45 PBP Data Report

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

Pharmacy

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

Non-Preferred Brand Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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

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

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

that apply for this Tier:

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

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

: Long Term Care Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

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

30 Enter number of days for Standard

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

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

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

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

supply for the first fill?

Yes

Yes

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

90 Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

31 Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

6/8/2021

about:blank

Page 41 of 45 PBP Data Report

**ICL** 

Indicate Copayment amount for Standard Retail \$100.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$190.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

: Brand

Coinsurance Indicate the type of cost-sharing structure:

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

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

that apply for this Tier:

: Standard Retail/Preferred Retail Cost Paring

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacv

Location/supply amount(s) that apply for this

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

Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Standard Mail Order Cost-Sharing - three

month supply

Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

6/8/2021 about:blank

30

PBP Data Report Page 42 of 45

Yes

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this Yes

tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

25%

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard 25%

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of- 25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term 25%

Care Pharmacy 1-month supply:

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

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

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

: Brand

Indicate the type of cost-sharing structure: Copayment

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

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

STRACION DE SALIO

PBP Data Report Page 43 of 45

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

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

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

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

No

90

30

90

Yes

ded :

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

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$8.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$16.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$3.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$6.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$6.00

Order Cost-Sharing 3-month supply:

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

6/8/2021

about:blank

PBP Data Report Page 44 of 45

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$3.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$0.27

Daily Preferred Retail Copayment \$0.10

Daily Copayment for Long-Term Care \$0.10

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

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

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Preferred Generic

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

Select the type of drug benefit: Actuarially Equivalent Standard

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 2

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Preferred Brand

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 3

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Non-Preferred Brand

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

Select the type of drug benefit: Actuarially Equivalent Standard

#

about:blank 6/8/2021

PBP Data Report Page 45 of 45

Tier Label Description

Specialty Tier

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

: Generic
: Brand

Tier Includes: Part D Drugs Only

Tier ID - OOP 5

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Select Care Drugs

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

Tier Includes: Part D Drugs Only

Tier ID - OOP 6

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D

Rewards and Incentives under the VBID

Model?

No





about:blank 6/8/2021

# TRIPLE-S ADVANTAGE, INC.

# APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5774-025





# PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 025, SEGMENT 0

Module: PBP

Requested By: gkdx

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 04:15:39 PM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 03:52:06 PM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 04:02:49 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 04:51:39 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02299

**PLAN STATUS** 

Section A Status Plan Ready for Upload

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

Section B11 Status Completed
Section B12 Status Completed
Section B13 Status Completed

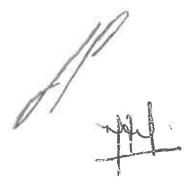
Section B14 Status Completed
Section B15 Status Completed
Section B16 Status Completed

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

Section D Status Completed
Section Mrx Status Completed

**SECTION A: SECTION A-1** 





Page 2 of 48

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

Service Area(s):

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

40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR





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

Service Area(s):

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

40330 - Hormigueros, PR 40340 - Humacao, PR





PBP Data Report

Page 4 of 48

	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H5774	
Plan ID:	025	
Segment ID:	0	
Contract Period:	2022	
7	Puerto Rico	
Plan Geographic Name:	No	
Is this an Employer-Only plan? SECTION A: SECTION A-2		
	69456	
Indicate CY2022 total projected member months for this plan:	05430	
Does this Plan have a CMS-approved Continuation Area?	No	
Do you intend to participate in the PLATINO program?	Yes	
Is this a Special Needs Plan?	Yes	
Special Needs Plan Type:	Dual-Eligible	
Is this D-SNP plan a Medicare zero-dollar cost	No	
sharing plan (this does not apply to Part D Services)?		
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	
SECTION A: SECTION A-3		
Participating Pharmacy Website Address:	www.sssadvantage.com	
Formulary Website Address:	www.sssadvantage.com	NINISTO
Physician Website Address:	www.sssadvantage.com	ADMINISTRACIO
Customer Service Contact Phone Number for	(888)620-1919	Contrato AL
Current Medicare Beneficiaries:		CO Million Nomero DM
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234	E AOS DE SALUD
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234	
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919	///
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919	f/ .
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)221-2234	Holy
SECTION A: SECTION A-4		
Customer Service Contact Local Phone Number	(833)221-2234	<b>1</b>

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
SECTION A: SECTION A-5	
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A: SECTION A-6	
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT HOSPITAL-A	
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	: Additional Days
Select type of benefit for Additional Days:	Mandatory
Is this benefit unlimited for Additional Days?	Yes
SECTION B: #1A INPATIENT HOSPITAL-A	CUTE - BASE 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
11	No

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an enrollee

Does this plan's Additional Days cost sharing

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

Is there an enrollee Coinsurance?

obtains care?





No

No

No

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

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

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

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

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

Acute Services?

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

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

Is there an enrollee Coinsurance?

No

No

No

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

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

Do you charge cost sharing on the day of No

discharge?
Is authorization required?
No
Is a referral required for Inpatient Psychiatric
No

Hospital Services?

# SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility No Services as a supplemental benefit under Part

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2





PBP Data Report

No

Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance? No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

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

Do you charge cost sharing on the day of

discharge?

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

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

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental

benefit under Part C?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Notes: Services in the USA may also be available

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

were provided.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment? No

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



Page 8 of 48 PBP Data Report

Services in the USA may also be available Notes:

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

were provided.

Mandatory

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

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency Mandatory

Coverage:

Select type of benefit for Worldwide Urgent

Coverage:

Is there a Maximum Plan Benefit Coverage Yes

amount for Worldwide Emergency/Urgent

Coverage?

Is the service-specific Maximum Plan Benefit No

Coverage amount unlimited?

Indicate Maximum Plan Benefit Coverage 75.00

amount:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Worldwide services are covered through Notes:

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 1 No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES = BASE 2

PBP Data Report

Page 9 of 48

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

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

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

Is authorization required?

Is a referral required for Chiropractic Services?

No

Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
No
No

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

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

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





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

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

Is authorization required?

Yes

Is a referral required for Physician Specialist

Yes

Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

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

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

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

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

Yes

supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Select type of benefit for Routine Foot Care: Mandatory

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

Every year Select the Routine Foot Care periodicity:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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





PBP Data Report

Is authorization required?

Is a referral required for Other Health Care

Professional Services?

No

Yes

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? No
Is a referral required for Psychiatric Services? No
SECTION B: #7I PT AND SP SERVICES - BASE 1
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

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

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services
: 7d: Physician Specialist Services

: 7el: 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?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required for Additional No Telehealth Services?

Is a referral required for Additional Telehealth Yes



Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

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

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

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

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

Is authorization required for Medicare-covered

Yes



Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

Yes

Is a referral required for Ambulatory Surgical

Center Services?

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

No

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

No

No

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

Is authorization required?

Is a referral required for Outpatient Substance No

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

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

WEST CONTRACT

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?

No

Is a referral required for Outpatient Blood

No

Services?



Page 14 of 48 PBP Data Report

Yes

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Any Health-related Location Select enhanced benefit:

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 24

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-One-way

related Location:

Select Mode of Transportation for Any Health-: Taxi : Van

related Location: : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Services?

Other methods of transportation are available, Notes: such as an automobile through a contracted

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No



Page 15 of 48 PBP Data Report

Out-of-Pocket Cost? Yes Is there an enrollee Coinsurance? Indicate Minimum Coinsurance percentage for 0% Medicare-covered Benefits: Indicate Maximum Coinsurance percentage for 5% Medicare-covered Benefits: No Is there an enrollee Deductible? No Is there an enrollee Copayment? **SECTION B: #11A DME - BASE 2** Are there preferred vendors/manufacturers for Yes Durable Medical Equipment (DME)?

Yes Is authorization required?

0% coinsurance for preferred brands and Notes: manufacturers.

5% coinsurance for non preferred brands and manufacturers.

# SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1 No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Yes Is there an enrollee Coinsurance?

: Medicare-covered Prosthetic Devices Select which Prosthetics/Medical Supplies have : Medicare-covered Medical Supplies a Coinsurance (Select all that apply):

Indicate Minimum Coinsurance percentage for 0% Medicare-covered Prosthetic Devices:

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

0% Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:

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

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

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

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

Yes Is authorization required?

5% coinsurance applies to surgically implanted Notes: prosthetics devices, urinary system & neurostimulator prosthetic devices.

0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices. 0% coinsurance for preferred brand medical

supplies and manufacturers.

5% coinsurance for non-preferred brand medical

supplies and manufacturers.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

Is there an enrollee Coinsurance?

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

**SECTION B: #12 DIALYSIS SERVICES - BASE 2** 

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

**SECTION B: #13A ACUPUNCTURE - BASE 3** 

Notes: Services are subject to the combined maximum

limit with Alternative therapy benefit.







Page 17 of 48 PBP Data Report

Yes

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

Select type of benefit for OTC Items: Mandatory

Yes Is there a service-specific Maximum Plan

Benefit Coverage amount? 100.00 Indicate Maximum Plan Benefit Coverage

amount: Every three months Select Maximum Plan Benefit Coverage

periodicity: Does your Maximum Plan Benefit Coverage No amount carry forward to the next period if it is

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

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

Nicotine Replacement Therapy (NRT) Attestation:

unused?

### SECTION B: #13B OTC ITEMS - BASE 2

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

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

### SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

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

OTC or formulary drugs.

No No No No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatologicals, Folic Acid, Iron, Laxatives,

Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor.

Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

### SECTION B: #13C MEAL BENEFIT - BASE 1

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

No



Page 18 of 48 PBP Data Report

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical

No

Yes

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

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

Hotline)\*

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

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory

Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

4

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Mandatory

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

Mandatory

Yes

Individual Sessions Indicate setting for Counseling Services:

Indicate duration of sessions (in minutes): 20

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

Select type of benefit for Alternative Therapies:

Is this benefit unlimited for Alternative

Therapies?

Mandatory

No, indicate number

Indicate number of visits offered for Alternative

Therapies:

12



Page 19 of 48 PBP Data Report

### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Νo

Benefit Coverage amount for Other Defined

Supplemental Benefits?

### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

No

### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

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

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

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

Supplemental Benefits? Health Education Notes:



This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management by health educators.

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

Remote Access Technologies (Nursing Hotline) Notes:

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

PBP Data Report Page 20 of 48

# SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:\*



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

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

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

NΤο

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

No

**Education Services?** 

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

No

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

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

Glaucoma Screening?

Is authorization required for Medicare-covered No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

No

No



PBP Data Report Page 21 of 48

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

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion Yes

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

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

Yes

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams?

No, indicate number

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

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

Indicate number of visits for Fluoride 1

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

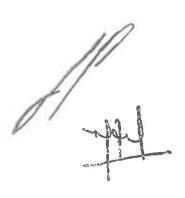
Select type of benefit for Dental X-Rays: Mandatory

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

Indicate number of visits for Dental X-Rays: 1

Select the Dental X-Rays periodicity: Other, Describe





Page 22 of 48 PBP Data Report

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required? No

Is a referral required for Preventive Dental

Services?

Up to (1) Panoramic image or Intraoral Notes:

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

images or Intraoral complete series, the

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

bitewings images per year.

# SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Yes

: Non-routine Services Select enhanced benefits:

: Diagnostic Services : Restorative Services

: Endodontics : Periodontics : Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Is this benefit unlimited for Non-routine

Services?

Mandatory

Yes

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic

Services?

Yes

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative

Services?

Yes

### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Yes Is this benefit unlimited for Endodontics?

Mandatory Select type of benefit for Periodontics:



PBP Data Report Page 23 of 48

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

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

Services?

Yes

Mandatory

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

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

type:

Indicate Maximum Plan Benefit Coverage 3500.00

amount:

Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental

Services?

Notes: Services are administered with the periodicity

No

established by the American Dental Association (ADA). Diagnostic services are not deducted from the annual maximum benefit limit and are administered with the periodicity established by the American Dental Association (ADA).

**SECTION B: #17A EYE EXAMS - BASE 1** 

Does the plan provide Eye Exams as a Yes supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

: Other

1

Select type of benefit for Routine Eye Exams: Mandatory

Is this benefit unlimited for Routine Eye

No, indicate number

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity: Every year

PBP Data Report Page 24 of 48

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:

Select the Other Service periodicity: Every six months

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

**SECTION B: #17A EYE EXAMS - BASE 3** 

Is authorization required?

Is a referral required for Eye Exams? No

Notes:

Routine eye exam: Test performed by physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eye

exam, consultation and prescription for eyewear

including refraction.

SECTION B: #17B EYEWEAR - BASE 1

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

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses : Eyeglass frames

: Upgrades

Yes

Select type of benefit for Contact lenses:

Mandatory
Is this benefit unlimited for Contact lenses?

Yes

Select type of benefit for Eyeglasses (lenses and Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

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

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes

Select type of benefit for Upgrades: Mandatory

**SECTION B: #17B EYEWEAR - BASE 3** 

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?



The state of the s

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

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit 1000.00

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

**SECTION B: #17B EYEWEAR - BASE 4** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #17B EYEWEAR - BASE 5** 

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear?

**SECTION B: #18A HEARING EXAMS - BASE 1** 

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Yes

Yes

Select type of benefit for Routine Hearing Mandatory

Exams:

Is this benefit unlimited for Routine Hearing No, indicate number

Exams?

Indicate number for Routine Hearing Exams: 1

Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation No, indicate number

for Hearing Aid?

Indicate number for Fitting/Evaluation for 1

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

The state of the s

PBP Data Report Page 26 of 48

**SECTION B: #18A HEARING EXAMS - BASE 3** 

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

SECTION B: #18B HEARING AIDS - BASE 1

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

Select enhanced benefits: : Hearing Aids (all types)

Yes

Select type of benefit for Hearing Aids (all Mandatory

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

**SECTION B: #18B HEARING AIDS - BASE 2** 

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Both ears combined

Amount apply per ear or for both ears

combined?

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

type.

Indicate Maximum Plan Benefit Coverage 2000.00

amount:

Indicate Maximum Plan Benefit Coverage Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

Is there an enrollee Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes

the Chronically III?

Select what type of benefit your SSBCI : Additional Benefits

includes:

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



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

#### SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

: Annual Wellness Visit

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person : Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

No

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

Engaged Annually:

7255

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

No

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

3

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

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

Which disease states does this benefit apply?

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Other 1

: Other 2

: Other 3

: Other 4



Page 28 of 48 PBP Data Report

: Other 5

Oncology Patients with Active Chemo by Other 1 Description:

Infusion or systemic radiotherapy

Acute Stroke Other 2 Description:

Hip, knee or open heart surgery Other 3 Description:

COPD patients with supplemental oxygen Other 4 Description:

dependency

Bedridden patients Other 5 Description:

Does the enrollee need to have all diseases

selected to qualify?

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

notes.

No No

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

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

deductible?

No

No

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

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

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

Notes:

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

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

- Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home
- Post Inpatient stay for Acute Stroke with transition of care to patient's home
- Oncology Patients with Active Chemo by Infusion or systemic radiotherapy
- Patients discharged from open heart surgery, hip surgery or knee surgery with transition of care to patient's home

- COPD patients with supplemental oxy

dependency

- Bedridden patients



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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

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

**BASE 3: PACKAGE #1** 

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

**BASE 12: PACKAGE #1** 

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

No No

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

BASE 14: PACKAGE #1

Is authorization required?
Is a referral required for Other Defined

No

Supplemental Benefits?

·No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

In-Home Support Services Notes:\*



Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, and 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, (4) hours per day for a maximum of (12) days in the calendar year.

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

#### PACKAGE #2

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders : Chronic heart failure

: Dementia

. Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD)

: Severe hematologic disorders

: HIV/AIDS

: Chronic lung disorders

: Chronic and disabling mental health conditions

: Neurologic disorders

: Stroke

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

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

No

: 13i: Non-Primarily Health Related Benefits for

the Chronically Ill

: 14c: Other Defined Supplemental Benefits

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

After member's clinical identification process, he/she will be sent a card with allowance for the purchase of food and groceries, grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants and of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Funds will be deposited once every quarter of the year while the member remains

active in the plan.

Page 31 of 48 PBP Data Report

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

Select what type of benefit your Non-Primarily

Health Related Benefits for the Chronically Ill

includes:

: Food and Produce

: Transportation for Non-Medical Needs

: General Supports for Living

#### SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Mandatory

Yes

Indicate Maximum Plan Benefit Coverage

amount:

225.00

No

Select Maximum Plan Benefit Coverage

periodicity:

Every three months

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Food and Produce?

#### SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:



Allowance is not cumulative and is restricted to the purchase of food and groceries and grocery delivery charges, combined with 13i General Supports for living (purchase of gasoline through contracted merchants and of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants) and with 14c Other Defined Supplemental Benefits (Thorough House Cleaning). 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, or cosmetics

#### SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -BASE 1: PACKAGE #2

Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?

Select enhanced benefit:

Yes

Any Location

Page 32 of 48 PBP Data Report

Mandatory Select type of benefit for Any Location:

Is this benefit unlimited for number of trips for No

Any Location?

0 Indicate number of trips for Any Location:

Every year Select Any Location Trips periodicity: Select Type of Transportation for Non-Medical One-way

Needs for Any Location:

Select Mode of Transportation for Non-Medical : Taxi : Van Needs for Any Location:

: Other, Describe

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -**BASE 2: PACKAGE #2** 

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -BASE 3: PACKAGE #2

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

Medical Needs?

Amount of trips is combined (not duplicated) Notes:

with the 10b trips for non-health related locations. Eligible members will have the flexibility of using transportation services to other locations such as churches, supermarkets

and financial institutions (i.e., banks).

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Yes Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for Mandatory

Living:

Yes Is there a service-specific Maximum Plan

Benefit Coverage amount?

225.00 Indicate Maximum Plan Benefit Coverage

amount:

Every three months Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2:



6/7/2021

Page 33 of 48 PBP Data Report

#### PACKAGE #2

Is there an enrollee Coinsurance? No No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Is a referral required for General Supports for No

Living?

#### SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #2

Notes:



Allowance is not cumulative and is restricted to the purchase of gasoline through contracted merchants and payment of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants and is combined with 13i Food and Produce (Food and groceries and groceries delivery charges) and with 14c Other Defined Supplemental Benefits (Thorough House Cleaning).

14C OTHER DEFINED SUPPLEMENTAL BENEFITS -SECTION B: VBID/OF/SBOTE BASE 1: PACKAGE #2

Yes

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

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

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

BASE 3: PACKAGE #2

Mandatory Select type of benefit for In-Home Support

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 4: PACKAGE #2** 

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

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

No

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

BASE 12: PACKAGE #2

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

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

file:///C:/Users/nicolego/AppData/Local/Temp/1/YN6KD1Q3.htm

6/7/2021

Page 34 of 48 PBP Data Report

#### BASE 14: PACKAGE #2

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

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #2

In-Home Support Services Notes:\*

Allowance is not cumulative and is restricted to thorough house cleaning performed by a contracted professional and is combined with 13I Food and Produce (Food and groceries and groceries delivery charges) and with 13i General Supports for living (purchase of gasoline through contracted merchants and payment of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants).

ENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: SECTION B: #19B PACKAGE #3

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #3

Which disease states does this benefit apply?

(Select all that apply):

: Other 1

Bedridden patients with specific essential Other 1 Description:

services requirements

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

Is there a prerequisite for any additional benefits No

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement?

No

No Is there a maximum benefit amount?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes:

Benefit is limited to bedridden patients with essential services requirements limited to

-Chemotherapy

-Oxygen dependency

-Ventilator

file:///C:/Users/nicolego/AppData/Local/Temp/1/YN6KD1Q3.htm

6/7/2021

Page 35 of 48 PBP Data Report

-Enteral Nutrition

-Specialty drugs (cancer/pulmonary

hypertension)

-CPAP

-Wound Care

-Ostomized

Besides having the eligible condition, member must meet with care manager at least once every quarter in order to have access to the benefit.

14C OTHER DEFINED SUPPLEMENTAL BENEFITS -SECTION B: VBID/NF/88BC/49

BASE 1: PACKAGE #3

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

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

BASE 3: PACKAGE #3

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 4: PACKAGE #3

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

BASE 7: PACKAGE #3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #3

Is there an enrollee Coinsurance?

No

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

BASE 12: PACKAGE #3

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

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

BASE 14: PACKAGE #3

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

Supplemental Benefits?

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

BASE 16: PACKAGE #3

In-Home Support Services Notes:\*

After meeting with the care manager once every quarter, the benefit will be available in blocks of

40 hours per quarter (not cumulative) for a

Page 36 of 48 PBP Data Report

> maximum of 160 hours per year. Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, medication reminders, noninvasive / non-clinical care such as diaper change or patient rotation to avoid ulcers, documentation and reporting back to the plan, coordinate doctor visits, plan coverage navigation to order refills and coordinate delivery using technology and escalation process to attend particular needs. 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.

#### SECTION B: #19C VBID HOSPICE-BASE 1

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

#### SECTION B: #19C VBID HOSPICE- BASE 2

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

#### **SECTION B: #19C VBID HOSPICE- BASE 3**

Are you offering hospice supplemental benefits? No Is there a max plan benefit amount?

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

Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.

Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.

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

Other mandatory supplemental benefits Describe other mandatory supplemental benefits:

SECTION B: #19C VBID HOSPICE- BASE 4

Yes

Yes

No

No

No

Yes

In-Home Support





Page 37 of 48 PBP Data Report

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. There isno cost sharing or copayment for hospice drugs and biologicals and hospice inpatient respite

care for both in-network and out-of-network hospice benefits.

: In-Network Medicare-covered benefits

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

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

ls there an In-Network Maximum Enrollee Out-Yes

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL No

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Actuarially Equivalent Standard

: Standard/Preferred Retail

: Out-of-Network

Voluntary

3400.00

Yes

Yes

: Standard Mail-Order

: Long-Term Care





Page 38 of 48 PBP Data Report

Yes

No

Yes

6 4

No

Sponsor attests that it will comply with 42 CFR

423.154.

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

#### SECTION RX: MEDICARE RX GENERAL 2

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

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

OTC Medication Attestation statement

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

MINISTRA

#### SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: What is your Formulary Exceptions Tier? Do you apply a second less expensive costsharing level for all generic drugs approved for formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

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

# SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

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

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

# SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

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

Cost Share Tiers

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

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

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

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

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

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

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

Page 39 of 48 PBP Data Report

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

: Standard Mail Order Cost-Sharing - three month supply

Select all Long-Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

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

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

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply: Are all of the drugs on your formulary for this

Yes

tier available with an extended day supply? Are any of the drugs available at an extended

No

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

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

ICL

\$19.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$28.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$28.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy I-month supply:

Indicate Copayment Amount for Long-Term \$14.00

Care Pharmacy 1-month supply:

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



OSDESP

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

Pharmacy

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

Tier Label Description

Generic

: Generic

Select the type of drug benefit:

Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

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

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

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

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

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier: Select all Standard Mail-Order Cost-Sharing

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

: Standard Mail Order Cost-Sharing - three month supply

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

: Long Term Care Pharmacy - one month supply

Tier:

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

30 Enter number of days for Standard

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

90 Enter number of days for Standard

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

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

Yes

Are any of the drugs available at an extended

No

day supply for this tier limited to a 1-month

supply for the first fill?

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

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

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

Enter number of days for Out-of-Network

30

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

31

Pharmacy 1-month supply:

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



Page 41 of 48 PBP Data Report

ICL

\$20.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

\$40.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$30.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$15.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Brand Tier Drug type(s) (select all that apply): Copayment Indicate the type of cost-sharing structure: SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

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

that apply for this Tier:

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

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

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

Tier:

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

Tier (Optional): Select all Long-Term Care Pharmacy

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

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supp

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

Contrato Na

Page 42 of 48 PBP Data Report

90

Yes

No

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

ICL

Indicate Copayment amount for Standard Retail \$47.00

Cost-Sharing 1-month supply:

\$94.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

\$84.00 Indicate Copayment amount for Preferred Retail

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$84.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

\$42.00 Indicate Copayment Amount for Long-Term

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

Page 43 of 48 PBP Data Report

Copayment Indicate the type of cost-sharing structure:

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

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

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

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

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

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

: Standard Mail Order Cost-Sharing - three month supply

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

: Long Term Care Pharmacy - one month supply

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

30 Enter number of days for Standard

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

90 Enter number of days for Standard

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

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

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

Yes

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

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

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

31 Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

\$100.00 Indicate Copayment amount for Standard Retail

Cost-Sharing I-month supply:

Indicate Copayment amount for Standard Retail \$200.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

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



Page 44 of 48 PBP Data Report

\$190,00

Indicate Copayment amount for Standard Mail-

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$95.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

Coinsurance Indicate the type of cost-sharing structure: SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

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

that apply for this Tier:

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

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

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

Tier:

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

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

; Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard 30

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

Enter number of days for Standard

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

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

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

Yes

90

Yes

Page 45 of 48 PBP Data Report

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

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

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

25% Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of-

25%

25%

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

Care Pharmacy 1-month supply:

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

Select Care Drugs Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

Copayment Indicate the type of cost-sharing structure: SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

OMINISTA

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

Select all Long-Term Care Pharmacy

one month supply

: Out-of-Network Pharmacy - one month supp

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

Page 46 of 48 PBP Data Report

Location/supply amount(s) that apply for this

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

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

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

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

supply for the first fill?

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL 90

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

31 Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

\$6.00

No

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

\$12.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$3.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$6.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$6.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$3.00

Care Pharmacy 1-month supply:

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

\$0.20 Daily Standard Retail Copayment \$0.10 Daily Preferred Retail Copayment \$0.10 Daily Copayment for Long-Term Care

Pharmacy



DESP

PBP Data Report Page 47 of 48

#### SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

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

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Preferred Generic

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 1

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

Select the type of drug benefit: Actuarially Equivalent Standard

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 2

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Preferred Brand

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Non-Preferred Brand

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

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 4

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description

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

Specialty Tier

Generic

Brand

Tier Includes: Part D Drugs Only

Tier ID - OOP 5

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

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Label Description Select Care Drugs

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







Page 48 of 48 PBP Data Report

No

: Brand apply):

Part D Drugs Only Tier Includes:

6 Tier ID - OOP

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID

Model?





# TRIPLE-S ADVANTAGE, INC.

# APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5774-026





Select Mode of Transportation for Any Health-

related Location:

: Taxi : Van

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

No No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

Notes:

Other methods of transportation are available, such as an automobile through a contracted provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Yes

Indicate Minimum Coinsurance percentage for

0%

Medicare-covered Benefits:

10%

Indicate Maximum Coinsurance percentage for

Medicare-covered Benefits: Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Yes

Is authorization required?

Yes

Notes:

0% coinsurance for preferred brands and

manufacturers.

10% coinsurance for non preferred brands and

manufacturers.

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Yes

Is there an enrollee Coinsurance? Select which Prosthetics/Medical Supplies have

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

a Coinsurance (Select all that apply): Indicate Minimum Coinsurance percentage for

Medicare-covered Prosthetic Devices:

0%

Indicate Maximum Coinsurance percentage for

10%



Medicare-covered Prosthetic Devices:

Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

0%

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

10%

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

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

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

Is authorization required? Yes

Notes: 10% coinsurance applies to surgically implanted

prosthetics devices, urinary system & neurostimulator prosthetic devices.

0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for Cardiovascular Devices.

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

manufacturers.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No
Do you limit Diabetic Supplies and Services to Yes those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
No
No

Is there an enrollee Copayment? No SECTION B: #12 DIALYSIS SERVICES - BASE 2
Is authorization required? No

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

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

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC) Yes





Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT)

Attestation:

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Mandatory

Yes

50.00

Every three months

No

No

Yes

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

OTC or formulary drugs.

No

No No

No



Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

### SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

Life

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

Medicare-covered Zero Dollar Preventive

Services Attestation

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

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

Is a referral required?

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

Does the plan provide the Annual Physical

No

No

No

Exam as a supplemental benefit under Part C?

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c1: Health Education

: 14c2: Nutritional/Dietary Benefit

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

Hotline)\*

Mandatory

: 14c9: Counseling Services

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Mandatory

4

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Individual Sessions

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

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

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services:

Is this benefit unlimited for Counseling

Services?

: Nursing Hotline

Mandatory

Mandatory

Yes

Indicate setting for Counseling Services:

Individual Sessions

20

Indicate duration of sessions (in minutes):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

No

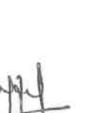
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

No



OSDES

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

No

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

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

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

Is authorization required?

Is a referral required for Other Defined

No
Supplemental Benefits?

Health Education Notes:



This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management by health educators.

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

Remote Access Technologies (Nursing Hotline) Notes: Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home..

Counseling Services Notes:

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

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

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

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

No



SDESP

Is a referral required for Kidney Disease

No

**Education Services?** 

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

No

Glaucoma Screening?

2.1

Is authorization required for Medicare-covered

No

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

No

Barium Enemas?

Ma

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

Is authorization required for Medicare-covered

No

EKG following Welcome Visit?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

Is Authorization Required?

Does the plan offer step therapy?

No

Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

Yes

drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

Yes

Select enhanced benefits:

: Oral Exams

: Prophylaxis (Cleaning)

J.

: Dental X-Rays Mandatory Select type of benefit for Oral Exams: No. indicate number Is this benefit unlimited for Oral Exams?

Indicate number of visits for Oral Exams:

Select the Oral Exams periodicity: Select type of benefit for Prophylaxis

(Cleaning):

Is this benefit unlimited for Prophylaxis

(Cleaning)?

Indicate number of visits for Prophylaxis

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity:

Select type of benefit for Fluoride Treatment:

Is this benefit unlimited for Fluoride Treatment?

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity:

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays:

Is this benefit unlimited for Dental X-Rays?

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

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

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

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

SECTION B: #16A PREVENTIVE DENTAL - BASE 5 No

Is authorization required? Is a referral required for Preventive Dental

Services?

Notes:

: Fluoride Treatment

Every six months

Mandatory

No. indicate number

1

Every six months

Mandatory

No, indicate number

Every six months

Mandatory No, indicate number

Other, Describe

No

No

No

No





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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Non-routine Services : Diagnostic Services

: Restorative Services

: Endodontics : Periodontics : Extractions

Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Is this benefit unlimited for Non-routine

Services?

Select type of benefit for Diagnostic Services:

Is this benefit unlimited for Diagnostic

Services?

Select type of benefit for Restorative Services:

Is this benefit unlimited for Restorative

Services?

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Is this benefit unlimited for Endodontics?

Select type of benefit for Periodontics:

Is this benefit unlimited for Periodontics?

Select type of benefit for Extractions:

Is this benefit unlimited for Extractions? Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

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

Services?

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Plan-specified amount per period

Yes

Yes

1000.00

Every year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type: Indicate Maximum Plan Benefit Coverage

amount;

Select the Maximum Plan Benefit Coverage periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

No





Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes No

Is a referral required for Comprehensive Dental

Services?

Notes:

Services are administered with the periodicity established by the American Dental Association (ADA). Diagnostic services are not deducted from the annual maximum benefit limit and are administered with the periodicity established by the American Dental Association (ADA).

# SECTION B: #17A EYE EXAMS - BASE 1

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

Select enhanced benefit:

Yes

: Routine Eye Exams

; Other

Mandatory

No, indicate number

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

Every year

Eyewear eye exam

Mandatory

No, indicate number

1

1

Every year

No

No

No

No

No

No

No

Routine eye exam: Test performed by physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eye exam, consultation and prescription for eyewear



including refraction. **SECTION B: #17B EYEWEAR - BASE 1** Yes

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

Select enhanced benefits:

: Contact lenses

: Eyeglasses (lenses and frames)

Plan-specified amount per period

: Eveglass lenses : Eyeglass frames : Upgrades

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

Select type of benefit for Eyeglasses (lenses and Mandatory frames):

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

Yes

Yes

SECTION B: #17B EYEWEAR - BASE 2

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

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

SECTION B: #17B EYEWEAR - BASE 3

Yes Is there a service-specific Maximum Plan Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type: Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 200.00

Coverage amount: Select the Combined Maximum Plan Benefit

Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4

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

Is there an enrollee Coinsurance? No

**SECTION B: #17B EYEWEAR - BASE 5** No Is there an enrollee Deductible? Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

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

SECTION B: #18A HEARING EXAMS - BASE 1 Yes Does the plan provide Hearing Exams as a



supplemental benefit under Part C?

: Routine Hearing Exams Select enhanced benefits:

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing Mandatory

Exams:

No. indicate number Is this benefit unlimited for Routine Hearing

Exams?

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation Yes

for Hearing Aid?

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

No Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

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

Is a referral required for Hearing Exams? SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a Yes

supplemental benefit under Part C?

: Hearing Aids (all types) Select enhanced benefits:

Mandatory Select type of benefit for Hearing Aids (all

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Both ears combined Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears combined?

Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage

Indicate Maximum Plan Benefit Coverage periodicity:

Plan-specified amount per period

500.00

Every year







SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

SECTION B: #18B HEARING AIDS - BASE 4

No Is there an enrollee Copayment? No

Is there an enrollee Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

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

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

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the Chronically III?

Yes Are you offering a VBID Hospice Benefit? Yes

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

In addition to wellness and health care planning,

what other interventions have you been

approved by CMMI to offer?

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

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

: Medicare Health Risk Assessment : Care Management Program

: Cash or Monetary Rebates

: In-home Assessments

: Web-Based

: Telephonic WHP Mode of Engagement (choose one or : In-Person more):

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

WHP Services?

Does your organization offer provider

incentives for offering or engaging beneficiaries in WHP activities?

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

Expected Number of Beneficiaries to be Engaged Annually:

No

No

: Electronic Health Records/Electronic Medical Records

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

2581





SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or Monetary Rebates: : Debit Card/Check

Cash or Monetary Rebates amount per month: 165.00
Maximum Annual Cash or Monetary Rebates 1980.00

ayailable:

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional 2

Benefits contain? (1-15)

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

Is this package applicable to VBID or MA MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

PACKAGE #1

Which disease states does this benefit apply? : Chronic Obstructive Pulmonary Disease

(Select all that apply): (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 or systemic radiotherapy

Other 2 Description: Acute Stroke

Other 3 Description: Hip, knee or open heart Surgery

Other 4 Description: COPD patients with supplemental oxygen

dependency

Other 5 Description: Bedridden patients

Does the enrollee need to have all diseases

selected to qualify?

Does the enrollee need to have a combination of

diseases selected to qualify? If yes, describe in notes.

No

No

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

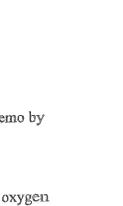
INFO): PACKAGE #1
Is there a prerequisite for any additional benefits No

for this package?

Select all the Non-Medicare-covered additional : 14c: Other Defined Supplemental Benefits

6/7/2021

-la -satublanle



benefits offered in this package:

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

Are any benefits exempt from the plan-level

deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

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

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

- Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home

- Post Inpatient stay for Acute Stroke with transition of care to patient's home

- Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

- Patients discharged from open heart surgery, hip surgery or knee surgery with transition of care to patient's home

- COPD patients with supplemental oxygen dependency

- Bedridden patients



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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

 $\mathbb{C}$ ?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

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

**BASE 3: PACKAGE #1** 

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

**BASE 7: PACKAGE #1** 

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

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

**BASE 12: PACKAGE #1** 

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

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

BASE 14: PACKAGE #1

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #1

In-Home Support Services Notes:\*



Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, and 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, (4) hours per day for a maximum of (12) days in the calendar year.

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

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

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

Which disease states does this benefit apply?

: Other 1

(Select all that apply):

Other 1 Description:

Bedridden patients with specific essential

services requirements

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

Is there a prerequisite for any additional benefits

No

for this package?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

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

Are any benefits exempt from the plan-level



deductible?

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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

No

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

Notes:

Benefit is limited to bedridden patients with essential services requirements limited to

-Chemotherapy

-Oxygen dependency

-Ventilator

-Enteral Nutrition

-Specialty drugs (cancer/pulmonary

hypertension)

-CPAP

-Wound Care

-Ostomized

Besides having the eligible condition, member must meet with care manager at least once every quarter in order to have access to the benefit.

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 3: PACKAGE #2

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

No

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

BASE 12: PACKAGE #2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

No

Supplemental Benefits?

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #2

In-Home Support Services Notes:\*



After meeting with the care manager once every quarter, the benefit will be available in blocks of 40 hours per quarter (not cumulative) for a maximum of 160 hours per year. Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, medication reminders, noninvasive / non-clinical care such as diaper change or patient rotation to avoid ulcers, documentation and reporting back to the plan, coordinate doctor visits, plan coverage navigation to order refills and coordinate delivery using technology and escalation process to attend particular needs. 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.

### SECTION B: #19C VBID HOSPICE-BASE 1

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

No Is there an enrollee Coinsurance?

SECTION B: #19C VBID HOSPICE- BASE 2

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

Is there an enrollee Coinsurance? SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits? Yes

No Is there a max plan benefit amount? Yes

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

Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.





Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.

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

Other mandatory supplemental benefits

Describe other mandatory supplemental

benefits:

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes



No

No

Yes

In-Home Support

Voluntary

3400.00

Yes

In-Home Support Benefit consisting of assistance by qualified staff for activities of daily living, such as help with bathing and dressing, transfer or assistance for mobility, light housekeeping (cleaning, laundry, dishes), meal preparation and medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider. There is no cost-sharing or copayment for drugs and biologicals or inpatient respite care for both innetwork and out-of-network hospice benefits.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

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

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

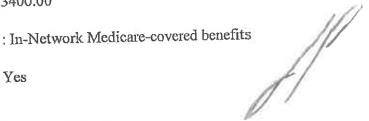
Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services? SECTION D: REDUCTIONS IN COST SHARING - GENERAL No

Do you offer Reductions in Cost Sharing? SECTION D: COMBINED BENEFITS - GENERAL

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

SECTION RX: MEDICARE RX GENERAL 1



Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

Sponsor attests that it will comply with 42 CFR 423.154.

#### SECTION RX: MEDICARE RX GENERAL 2

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

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

OTC Medication Attestation statement

Yes

Actuarially Equivalent Standard

· Standard/Preferred Retail

: Out-of-Network

: Standard Mail-Order

: Long-Term Care

: Sponsor attests that it will comply with 42

CFR 423.154.

Yes

No

Yes

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

#### SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit:

What is your Formulary Exceptions Tier?

Do you apply a second less expensive cost-

sharing level for all generic drugs approved for

formulary exceptions?

6 4

No

#### SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to

select):

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

## SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) cost-

sharing structure for this plan:

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

the Standard Retail allowable\*\*

## SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Cost Share Tiers

Initial Coverage Limit (ICL) is reached?

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

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

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

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

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

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

: Out-of-Network Pharmacy - one month supply

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

: Standard Mail Order Cost-Sharing - three month supply

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

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

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

month supply:

90 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply? Are any of the drugs available at an extended

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

Yes

No

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

30 Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail \$19.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$38.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing 1-month supply:

\$28.00 Indicate Copayment amount for Preferred Retail

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-\$28.00

Order Cost-Sharing 3-month supply:



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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$14.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

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

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

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

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

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

that apply for this Tier:

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

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

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

: Standard Mail Order Cost-Sharing - three month supply

Tier (Optional):
Select all Long-Term Care Pharmacy : Long Term Care Pharmacy - one month supply

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

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

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

month supply:
Enter number of days for Standard 90

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

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

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

Yes

No

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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:



POSDE

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

30 Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

\$20.00

\$30.00

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

\$15.00 Indicate Copayment amount for Preferred Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail-

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$15.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

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

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

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

that apply for this Tier:

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

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

: Standard Mail Order Cost-Sharing - three month supply





Select all Long-Term Care Pharmacy

: Long Term Care Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

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

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

month supply:

Enter number of days for Standard 90

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

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

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

supply for the first fill?



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

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

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

Yes

No

Indicate Copayment amount for Standard Retail \$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Standard Mail- \$84.00

Order Cost-Sharing 3-month supply:

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

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

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

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

Daily Standard Retail Copayment \$1.57

Daily Preferred Retail Copayment \$1.40

Daily Copayment for Long-Term Care \$1.35

Pharmacy

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

Tier Label Description

Non-Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Includes:

Part D Drugs Only

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

: Brand

Indicate the type of cost-sharing structure:

Copayment

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

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

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

: Out-of-Network Pharmacy - one month supply

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

: Standard Mail Order Cost-Sharing - three month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

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

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

90

Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Yes

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

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

supply for the first fill?

Yes



Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

90

Pharmacy in your 1-month supply:

31

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

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

Indicate Copayment amount for Standard Retail

\$100.00

Cost-Sharing 1-month supply:



Indicate Copayment amount for Standard Retail \$200.00 Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing 3-month supply:

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

ontrato Númer

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

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

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

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

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

Pharmacy

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

Tier Label Description

Specialty Tier

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Includes:

Part D Drugs Only

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

: Generic : Brand

Indicate the type of cost-sharing structure:

Coinsurance

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

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

that apply for this Tier:

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

: Standard Retail/Preferred Retail Cost-Sharing -

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

month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

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

: Standard Mail Order Cost-Sharing - three

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

30



Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

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

Yes

Are any of the drugs available at an extended

Yes

day supply for this tier limited to a 1-month

supply for the first fill?

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

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

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

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

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

ICL

Indicate Coinsurance percentage for Standard

Retail Cost-Sharing 1-month supply:

\_\_\_\_

25%

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing 3-month supply:

25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:

25%

Indicate Coinsurance percentage for Preferred

Retail Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Standard

25%

Mail-Order Cost-Sharing 3-month supply:

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

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

25%

Care Pharmacy 1-month supply:

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

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Includes:

Part D Drugs Only

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

: Generic

: Brand

Indicate the type of cost-sharing structure:

Copayment

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

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

that apply for this Tier:

about blank

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing

three month supply

6/7/2021



Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

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

Tier (Optional):

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

Tier:

: Out-of-Network Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

month supply

30

90

Yes

No

: Long Term Care Pharmacy - one month supply

OSDES

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

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month supply for the first fill?

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL 90

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

30

31

Indicate Copayment amount for Standard Retail \$10,00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$5.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$10.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICI

Indicate Copayment amount for Standard Mail-\$10.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$10.00

Pharmacy 1-month supply:

\$5.00 Indicate Copayment Amount for Long-Term

6/7/2021

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

\$0.33 Daily Standard Retail Copayment \$0.17 Daily Preferred Retail Copayment Daily Copayment for Long-Term Care \$0.16

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

Medicare-defined Post Threshold Cost Shares How do you apply your cost sharing beyond the Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Generic

apply):

Part D Drugs Only Tier Includes:

Tier ID - OOP

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Select drug type(s) in this Tier (select all that

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Actuarially Equivalent Standard Select the type of drug benefit:

Preferred Brand

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

3 Tier ID - OOP

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

4 Tier ID - OOP

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Select drug type(s) in this Tier (select all that : Brand apply):



Part D Drugs Only Tier Includes:

5 Tier ID - OOP

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Select Care Drugs

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Select drug type(s) in this Tier (select all that : Brand apply):

Part D Drugs Only Tier Includes:

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D

Rewards and Incentives under the VBID

Model?

Tier ID - OOP





## TRIPLE-S ADVANTAGE, INC.

# APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5774-028



PBP Data Report Page 1 of 43

#### PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 028, SEGMENT 0

Module: PBP Requested By: rsx9

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 04:15:05 PM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 03:53:42 PM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 04:03:34 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 04:51:39 PM SA Western Standard

Time

Upload Status: 06/07/2021 #02299

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Completed Section B7 Status Completed Section B8 Status Section B9 Status Completed Section B10 Status Completed

Section B11 Status Completed
Section B12 Status Completed
Section B13 Status Completed
Section B14 Status Completed

Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed
Section B18 Status Completed
Section B19 Status Completed

Section C Status Completed
Section D Status Completed
Section Mrx Status Completed

**SECTION A: SECTION A-1** 



6/7/2021

PBP Data Report Page 2 of 43

Organization Legal Name: TRIPLE S ADVANTAGE, INC. Triple S Advantage Organization Marketing Name: Organization Web Site: www.sssadvantage.com Plan Name: Platino Blindao (HMO D-SNP) Local CCP Organization Type: **HMO** Plan Type: Enrollee Type: Part A and Part B 40010 - Adjuntas, PR Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): Service Area(s): 40050 - Aibonito, PR Service Area(s): 40060 - Anasco, PR 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR Service Area(s): Service Area(s): 40090 - Barceloneta, PR Service Area(s): 40100 - Barranquitas, PR 40110 - Bayamon, PR Service Area(s): 40120 - Cabo Rojo, PR Service Area(s): Service Area(s): 40130 - Caguas, PR Service Area(s): 40140 - Camuy, PR Service Area(s): 40145 - Canovanas, PR 40150 - Carolina, PR Service Area(s): Service Area(s): 40160 - Catano, PR Service Area(s): 40170 - Cayey, PR DMINISTRA 40180 - Ceiba, PR Service Area(s): Service Area(s): 40190 - Ciales, PR 40200 - Cidra, PR Service Area(s): 40210 - Coamo, PR Service Area(s): m Service Area(s): 40220 - Comerio, PR POSDESA Service Area(s): 40230 - Corozal, PR 40240 - Culebra, PR Service Area(s): Service Area(s): 40250 - Dorado, PR 40260 - Fajardo, PR Service Area(s): Service Area(s): 40265 - Florida, PR Service Area(s): 40270 - Guanica, PR 40280 - Guayama, PR Service Area(s): 40290 - Guayanilla, PR Service Area(s): Service Area(s): 40300 - Guaynabo, PR 40310 - Gurabo, PR Service Area(s): 40320 - Hatillo, PR Service Area(s):

about:blank 6/7/2021

Service Area(s):

PBP Data Report Page 3 of 43

	40330 - Hormigueros, PR
Company Arranga V	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	,
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	•

Contrato Namero DE

PBP Data Report Page 4 of 43

	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5774
Plan ID:	028
Segment ID:	0
Contract Period:	2022
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A: SECTION A-2	
Indicate CY2022 total projected member months for this plan:	144756
Does this Plan have a CMS-approved Continuation Area?	No
Do you intend to participate in the PLATINO program?	Yes
Is this a Special Needs Plan?	Yes
Special Needs Plan Type:	Dual-Eligible
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	Yes Dual-Eligible No
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No DESALUD
SECTION A: SECTION A-3	
Participating Pharmacy Website Address:	www.sssadvantage.com
Formulary Website Address:	www.sssadvantage.com
Physician Website Address:	www.sssadvantage.com
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)221-2234
SECTION A: SECTION A-4	
Customer Service Contact Local Phone Number	(833)221-2234

PBP Data Report Page 5 of 43

for Prospective Part D Medicare Beneficiaries:	
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520
SECTION A: SECTION A-5	
Is your organization filing a standard bid for	No

Is your organization filing a standard bid for No Section B of the PBP?

Is your organization filing a standard bid for No

Section C of the PBP?

**SECTION A: SECTION A-6** 

Is your organization filing a standard bid for Section D of the PBP?

Do any of your outpatient services have tiered No

Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1

Does the plan provide Inpatient Hospital-Acute Yes Services as a supplemental benefit under Part C?

Select enhanced benefits: : Additional Days

Select type of benefit for Additional Days: Mandatory

Is this benefit unlimited for Additional Days? Yes

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5

Does this plan's Additional Days cost sharing No





vary by hospital(s) in which an enrollee obtains care?

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

No Is there an enrollee Deductible? No Is there an enrollee Copayment?

#### SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

Per Admission or Per Stay What is your Inpatient Hospital-Acute benefit

period?

Do you charge cost sharing on the day of No

discharge?

No Is authorization required? Is a referral required for Inpatient Hospital-No

Acute Services?

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance? No

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

#### SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

What is your Inpatient Hospital Psychiatric Per Admission or Per Stay benefit period?

Do you charge cost sharing on the day of

discharge?

Is authorization required? No

Is a referral required for Inpatient Psychiatric No

Hospital Services?

#### **SECTION B: #2 SNF - BASE 1**

Does the plan provide Skilled Nursing Facility No Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital No

stay prior to SNF admission?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

**SECTION B: #2 SNF - BASE 2** 



6/7/2021 about:blank

No

PBP Data Report Page 7 of 43

No

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

**SECTION B: #2 SNF - BASE 6** 

Is there an enrollee Copayment? No

**SECTION B: #2 SNF - BASE 10** 

What is your SNF benefit period? Per Admission or Per Stay

Do you charge cost sharing on the day of No

discharge?

Is authorization required? Yes
Is a referral required for SNF Services? No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental

benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?

Notes: Services in the USA may also be available

through reimbursement in accordance with Medicare rates and the location where services

were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment? No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

Page 8 of 43 PBP Data Report

Notes: Services in the USA may also be available

> through reimbursement in accordance with Medicare rates and the location where services

were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage

: Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

Coverage?

Yes

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

amount:

75.00

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

#### SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No Is there an enrollee Deductible? No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes: Worldwide services are covered through

reimbursement in accordance with Triple-S

Advantage rates.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Partial Hospitalization? No

**SECTION B: #6 HOME HEALTH SERVICES - BASE 1** 

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2



6/7/2021 about:blank

PBP Data Report Page 9 of 43

Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Home Health Services? No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

**SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1** 

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care
Select type of benefit for Routine Care: Mandatory

Is this benefit unlimited for Routine Care?

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Occupational Therapy No

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?





Page 10 of 43 PBP Data Report

Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Is authorization required? Yes Is a referral required for Physician Specialist Yes

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

Is authorization required? No Is a referral required for Mental Health No

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Routine Foot Care

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 4

Select the Routine Foot Care periodicity: Every year

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7F PODIATRY SERVICES - BASE 3

Is authorization required? No Is a referral required for Podiatrist Services? Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2





about:blank 6/7/2021

PBP Data Report Page 11 of 43

Is authorization required? No
Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? No
Is a referral required for Psychiatric Services? No

SECTION B: #71 PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may have Additional Telehealth Benefits available: : 7a: Primary Care Physician Services : 7d: Physician Specialist Services

: 7e1: Individual Sessions for Mental Health

**Specialty Services** 

: 7h1: Individual Sessions for Psychiatric

Services

No

No

: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance? No
Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional No

Telehealth Services?

Is a referral required for Additional Telehealth Yes





PBP Data Report Page 12 of 43

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required? No
Is a referral required for Opioid Treatment No

Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible? No
Is there an enrollee Copayment? No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE

Is authorization required? Yes
Is a referral required for Outpatient No
Diagnostic/Therapeutic Radiological, and X-

Ray Services?

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible? No
Is there an enrollee Copayment? No
Is authorization required for Medicare-covered Yes



PBP Data Report Page 13 of 43

Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

**Observation Services?** 

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #9B ASC SERVICES - BASE 2** 

Is there an enrollee Deductible?

Is there an enrollee Copayment? No
Is authorization required? Yes

Is authorization required? Yes
Is a referral required for Ambulatory Surgical No

Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

Is authorization required? No
Is a referral required for Outpatient Substance No

Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

Select enhanced benefit: : Three (3) Pint Deductible Waived

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?



14

PBP Data Report Page 14 of 43

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Any Health-related Location

Select type of benefit for Any Health-related Mandatory

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 36

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-

related Location:

Select Mode of Transportation for Any Health- : Taxi

related Location: : Van : Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Transportation

No

Services?

Notes: Other methods of transportation are available,

such as an automobile through a contracted

provider.

One-way

**SECTION B: #11A DME - BASE 1** 

Is there a service-specific Maximum Enrollee No

PBP Data Report Page 15 of 43

Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11A DME - BASE 2	
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and
	manufacturers.
	5% coinsurance for non-preferred brands and manufacturers.
SECTION B: #11B PROSTHETICS/MEDICA	
Is there a service-specific Maximum Enrollee	No
Out-of-Pocket Cost?	110
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% ADMINISTRACION
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0% Contrato Número
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	L SUPPLIES - BASE 2
SECTION B: #11B PROSTHETICS/MEDICA	L SUPPLIES - BASE 2
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
SECTION B: #11B PROSTHETICS/MEDICA	L SUPPLIES - BASE 3
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted

prosthetics devices, urinary system & neurostimulator prosthetic devices.

0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices.

0% coinsurance for Cardiovascular Devices.

0% coinsurance for preferred brand medical

supplies and manufacturers.

5% coinsurance for non-preferred brand medical

supplies and manufacturers.

PBP Data Report Page 16 of 43

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment? No
Do you limit Diabetic Supplies and Services to
Yes

those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

**SECTION B: #12 DIALYSIS SERVICES - BASE 2** 

Is authorization required? No
Is a referral required for Dialysis Services? No

**SECTION B: #13A ACUPUNCTURE - BASE 1** 

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

**SECTION B: #13A ACUPUNCTURE - BASE 2** 

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13A ACUPUNCTURE - BASE 3

Notes: Services are subject to the combined maximum

limit with Alternative therapy benefit.

**SECTION B: #13B OTC ITEMS - BASE 1** 

6/7/2021

about:blank

PBP Data Report Page 17 of 43

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT) Attestation:

#### **SECTION B: #13B OTC ITEMS - BASE 2**

Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

#### SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Mandatory

Yes

100.00

Every three months

No

No

Yes

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

No No No

No



Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Dermatologicals, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Otic Agents, Urinary Analgesics, Vaginal Products, Vitamins, Adult Diapers/Pads and Blood Pressure Monitor.

Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

#### **SECTION B: #13C MEAL BENEFIT - BASE 1**

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.

No



PBP Data Report Page 18 of 43

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive : I attest that there is no coinsurance, Services Attestation

copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required? No Is a referral required? No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical No

Exam as a supplemental benefit under Part C?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education

14c2: Nutritional/Dietary Benefit

: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing

> S m

Hotline)\*

4

Yes

: 14c9: Counseling Services : 14c17: Alternative Therapies\*

No, indicate number

: Nursing Hotline

Select type of benefit for Health Education: Mandatory Select type of benefit for Nutritional/Dietary Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit: Individual Sessions

Select type of benefit for Remote Access Mandatory Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Select type of benefit for Counseling Services: Mandatory

Is this benefit unlimited for Counseling

Services?

Indicate setting for Counseling Services: Individual Sessions

Indicate duration of sessions (in minutes): 20

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative 12

Therapies:

PBP Data Report Page 19 of 43

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required? No
Is a referral required for Other Defined No

Supplemental Benefits?

Health Education Notes: This program provides health information and

promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management

by health educators.

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline) Notes: Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their 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.

PBP Data Report Page 20 of 43

#### SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:\* Services are subject to the combined maximum

limit with Acupuncture benefits. Alternative

Therapies include:

• Chinese Medicine

Pranic Healing

• Music Therapy

• Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or

undesirable behaviors, such as sleeping and learning disorders and communication issues)

• Naturopathic Medicine

• Traditional Chinese Medicine

Reflexology

#### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

#### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

No

**Education Services?** 

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

No

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

Is there an enrollee Copayment? No
Is authorization required for Medicare-covered No

Glaucoma Screening?

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

No

Is authorization required for Medicare-covered

No

Barium Enemas?

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

Is authorization required for Medicare-covered

No

EKG following Welcome Visit?

#### SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

No

6/7/2021

SDESP

PBP Data Report Page 21 of 43

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance? No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes
Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply): Part B to Part B?

: Part D to Part B?

Yes

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

drugs as part of a bundled service as a mandatory supplemental benefit?

**SECTION B: #16A PREVENTIVE DENTAL - BASE 1** 

Does the plan provide Preventive Dental Items Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

: Prophylaxis (Cleaning) : Fluoride Treatment : Dental X-Rays

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams? No, indicate number

Indicate number of visits for Oral Exams: 1

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

Is this benefit unlimited for Fluoride Treatment? No, indicate number

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

Is this benefit unlimited for Dental X-Rays?

No, indicate number

Indicate number of visits for Dental X-Rays: 1

Select the Dental X-Rays periodicity: Other, Describe





about:blank 6/7/2021

1

PBP Data Report Page 22 of 43

Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

**SECTION B: #16A PREVENTIVE DENTAL - BASE 3** 

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required? No
Is a referral required for Preventive Dental No

Services?

Notes: Up to (1) panoramic image or intraoral complete

series including bitewings, every (3) 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, including up to (4) periapical and up to (2)

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Items as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Non-routine Services: Diagnostic Services: Restorative Services

: Endodontics : Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine Yes

Services?

Select type of benefit for Diagnostic Services: Mandatory

Is this benefit unlimited for Diagnostic Yes

Services?

Select type of benefit for Restorative Services: Mandatory

Is this benefit unlimited for Restorative Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

ROMINISTRACION DE SALIPOS DE SALIPO



PBP Data Report Page 23 of 43

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Services?

Yes

Yes

Mandatory

#### SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage 2000.00

amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Every year

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental

Services?

No

Services are administered with the periodicity Notes:

established by the American Dental Association (ADA). Diagnostic services are not deducted from the annual maximum benefit limit and are administered with the periodicity established by

the American Dental Association (ADA).

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Yes

Select enhanced benefit: : Routine Eye Exams

: Other

Select type of benefit for Routine Eye Exams:

Is this benefit unlimited for Routine Eye

Exams?

Mandatory

No, indicate number

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity:

Every year



6/7/2021 about:blank

1

PBP Data Report Page 24 of 43

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:

Select the Other Service periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? Nο Is there an enrollee Deductible? No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No

Is a referral required for Eye Exams? No

Routine eye exam: Test performed by physician Notes: to evaluate the need to have eyewear. If eyewear

is needed, the plan will cover under Other eye exam, consultation and prescription for eyewear

including refraction.

SECTION B: #17B EYEWEAR - BASE 1

Yes Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits: : Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses

: Eyeglass frames : Upgrades

Mandatory Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

**SECTION B: #17B EYEWEAR - BASE 2** 

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Select type of benefit for Upgrades:

**SECTION B: #17B EYEWEAR - BASE 3** 

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Yes

Mandatory



NISTR.

POSDESP

PBP Data Report Page 25 of 43

Select the Maximum Plan Benefit Coverage Plan-specified amount per period Do you offer a Combined Max Plan Benefit Yes Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit 500.00 Coverage amount: Select the Combined Maximum Plan Benefit Every year Coverage periodicity: SECTION B: #17B EYEWEAR - BASE 4 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #17B EYEWEAR - BASE 5 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #17B EYEWEAR - BASE 6 No Is authorization required? Is a referral required for Eyewear? No SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a Yes supplemental benefit under Part C? Select enhanced benefits: : Routine Hearing Exams Fitting/Evaluation for Hearing Aid Select type of benefit for Routine Hearing Mandatory Exams: Is this benefit unlimited for Routine Hearing No, indicate number Exams? Indicate number for Routine Hearing Exams: Select Routine Hearing Exams periodicity: Every year Select type of benefit for Fitting/Evaluation for Mandatory Hearing Aid: Is this benefit unlimited for Fitting/Evaluation No, indicate number for Hearing Aid? Indicate number for Fitting/Evaluation for 1 Hearing Aid: Select Fitting/Evaluation for Hearing Aid Every year periodicity: SECTION B: #18A HEARING EXAMS - BASE 2 Is there a service-specific Maximum Plan No Benefit Coverage amount? Is there an enrollee Deductible? No Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No

PBP Data Report Page 26 of 43

**SECTION B: #18A HEARING EXAMS - BASE 3** 

Is there an enrollee Copayment? No
Is authorization required? No
Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all Mandatory

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

**SECTION B: #18B HEARING AIDS - BASE 2** 

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Does the Maximum Plan Benefit Coverage Both ears combined

Amount apply per ear or for both ears

combined?

Select the Maximum Plan Benefit Coverage Plan-specified amount per period

type

Indicate Maximum Plan Benefit Coverage 1500.00

amount:

Indicate Maximum Plan Benefit Coverage Every year

periodicity:

**SECTION B: #18B HEARING AIDS - BASE 3** 

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #18B HEARING AIDS - BASE 4** 

Is there an enrollee Copayment? No
Is there an enrollee Deductible? No

**SECTION B: #18B HEARING AIDS - BASE 5** 

Is authorization required? No
Is a referral required for Hearing Aids? No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for No

the Chronically Ill?

Are you offering a VBID Hospice Benefit? Yes
Are you offering Part C benefits under the No

VBID Model? (VBID Part D Rewards and Incentives programs should be entered in





Page 27 of 43 PBP Data Report

Section Rx)

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Annual Wellness Visit

: Medicare Health Risk Assessment

Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic In-Person Web-Based

Does your organization offer Part C Rewards or

Incentives for beneficiaries for the offer of

WHP Services?

No

Yes

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

Engaged Annually:

11192

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

Benefits contain? (1-15)

Yes

No

2

#### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #1

Which disease states does this benefit apply?

(Select all that apply):

: Chronic Obstructive Pulmonary Disease

(COPD)

: Congestive Heart Failure (CHF)

: Other 1

: Other 2

Other 3

Other 4

: Other 5

Oncology Patients with Active Chemo by Other 1 Description:

about:blank

6/7/2021

PBP Data Report Page 28 of 43

Infusion or systemic radiotherapy

Other 2 Description: Acute Stroke

Other 3 Description: Hip, knee or open heart surgery

Other 4 Description: COPD patients with supplemental oxygen

dependency

Other 5 Description: Bedridden patients

Does the enrollee need to have all diseases

selected to qualify?

No

No

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in

notes.

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits No

for this package?

.VO

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? No

#### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

Benefit eligibility will be based on medical recommendation, and the following conditions:

- Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home
- Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home
- Post Inpatient stay for Acute Stroke with transition of care to patient's home
- Oncology Patients with Active Chemo by Infusion or systemic radiotherapy
- Patients discharged from open heart surgery, hip surgery or knee surgery with transition of care to patient's home
- COPD patients with supplemental oxygen dependency
- Bedridden patients

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined

Yes

PBP Data Report Page 29 of 43

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply): : 14c21: In-Home Support Services\*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #1

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 12: PACKAGE #1

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 14: PACKAGE #1

Is authorization required? No Is a referral required for Other Defined No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #1

In-Home Support Services Notes:\*

Contrato Namero M CONTRACION CONTRACION M CONTRACION CONTRACION CONTRACION CONTRACION CO Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, and 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, (4) hours per day for a maximum of (12) days in the calendar year.

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPES PACKAGE #2

Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?

MA Uniformity Flexibility

Page 30 of 43 PBP Data Report

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #2

: Other 1

Which disease states does this benefit apply?

(Select all that apply): Other 1 Description:

Bedridden patients with specific essential

services requirements

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

No

Nο

Is there a prerequisite for any additional benefits

for this package?

: 14c: Other Defined Supplemental Benefits

Select all the Non-Medicare-covered additional benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

deductible?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:

Benefit is limited to be ridden patients with essential services requirements limited to

-Chemotherapy

-Oxygen dependency

-Ventilator

-Enteral Nutrition

-Specialty drugs (cancer/pulmonary

hypertension)

-CPAP

-Wound Care

-Ostomized

Besides having the eligible condition, member must meet with care manager at least once every quarter in order to have access to the benefit.

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 1: PACKAGE #2

Does the plan provide Other Defined Yes

Supplemental Benefits as a benefit under Part

C?

: 14c21: In-Home Support Services\* Select enhanced benefit (Select all that apply):

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENE

BASE 3: PACKAGE #2

Select type of benefit for In-Home Support Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFI BASE 4: PACKAGE #2

PBP Data Report Page 31 of 43

No

No

Is there a service-specific Maximum Plan

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #2

Is there an enrollee Coinsurance?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 12: PACKAGE #2

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14: PACKAGE #2

Is authorization required? No
Is a referral required for Other Defined No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #2

In-Home Support Services Notes:\*



After meeting with the care manager once every quarter, the benefit will be available in blocks of 40 hours per quarter (not cumulative) for a maximum of 160 hours per year. Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, medication reminders, noninvasive / non-clinical care such as diaper change or patient rotation to avoid ulcers, documentation and reporting back to the plan, coordinate doctor visits, plan coverage navigation to order refills and coordinate delivery using technology and escalation process to attend particular needs. 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.

#### **SECTION B: #19C VBID HOSPICE- BASE 1**

Is there an enrollee Coinsurance? No
Is there an enrollee Copayment? No
Is there an enrollee Coinsurance? No

**SECTION B: #19C VBID HOSPICE- BASE 2** 

Is there an enrollee Coinsurance?

PBP Data Report Page 32 of 43

Yes

No

No

No

Yes

In-Home Support

No Is there an enrollee Copayment? Is there an enrollee Coinsurance? No

**SECTION B: #19C VBID HOSPICE- BASE 3** 

Yes Are you offering hospice supplemental benefits? Is there a max plan benefit amount? No

Are hospice supplemental benefits contingent upon receiving services from an in-network provider?

Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.

Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.

Reduced cost sharing for unrelated medical care services received during hospice election

Other mandatory supplemental benefits

Describe other mandatory supplemental benefits:

**SECTION B: #19C VBID HOSPICE- BASE 4** 

Hospice notes



In-Home Support Benefit consisting of assistance by qualified staff for activities of daily living, such as help with bathing and dressing, transfer or assistance for mobility, light housekeeping (cleaning, laundry, dishes), meal preparation and medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider. There is no cost-sharing or copayment for drugs and biologicals or inpatient respite care for both innetwork and out-of-network hospice benefits.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program? No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-

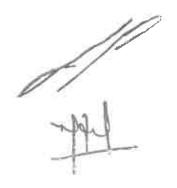
of-Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Yes

Voluntary



Page 33 of 43 PBP Data Report

3400.00

No

Yes

: Standard/Preferred Retail

: Out-of-Network : Standard Mail-Order Long-Term Care

CFR 423.154.

: In-Network Medicare-covered benefits

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-Yes

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Select the type of drug benefit: Actuarially Equivalent Standard

Describe the components of your pharmacy

network (select all that apply):

Sponsor attests that it will comply with 42 CFR

423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Yes Does plan utilize ceiling pricing? No

Do you pay for over-the-counter medications (OTCs) under the utilization management

program?

OTC Medication Attestation statement : Per Chapter 4 of the Medicare Managed Care

Yes

No

Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

: Sponsor attests that it will comply with 42

SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6

4 What is your Formulary Exceptions Tier?

Do you apply a second less expensive cost-

sharing level for all generic drugs approved for

formulary exceptions?

SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to

select):

Preferred Generic, Generic, Preferred Brand, Non-Preferred Brand, Specialty Tier, Select

Care Drugs

SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS





Page 34 of 43 PBP Data Report

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable\*\*

#### SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL

How do you apply your cost sharing before the

Initial Coverage Limit (ICL) is reached?

Cost Share Tiers

#### SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Preferred Generic Tier Label Description

Select the type of drug benefit: Actuarially Equivalent Standard

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment

#### SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three

month supply

Long Term Care Pharmacy - one month supply

#### SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

Yes

No

#### SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

90

#### SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30 Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

PBP Data Report Page 35 of 43

Pharmacy 1-month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

\$15.00

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$30.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$10.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$20.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$20.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$15.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$10.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.50

Daily Preferred Retail Copayment \$0.33

Daily Copayment for Long-Term Care \$0.32

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Generic
Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-

Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing - one month supply

S

OSDESA

: Standard Retail/Preferred Retail Cost-Sharing -

: Out-of-Network Pharmacy - one month supply

Long Term Care Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

-144

PBP Data Report Page 36 of 43

Yes

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Are any of the drugs available at an extended No

day supply for this tier limited to a 1-month

supply for the first fill?

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$20.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$40.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$15.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$30.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #2 - MAIL-ORDER COPAYMENT AND COINSTITANCE - PRE-ICI

Indicate Copayment amount for Standard Mail- \$30.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$20.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$15.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.67

Daily Preferred Retail Copayment \$0.50

Daily Copayment for Long-Term Care \$0.48

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Preferred Brand

Select the type of drug benefit:

Actuarially Equivalent Standard

PBP Data Report Page 37 of 43

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Brand
Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this

Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

#### SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

No

Yes

90



#### SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

#### SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

# SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRIJICL

Indicate Copayment amount for Standard Retail \$47.00 Cost-Sharing 1-month supply:

cost sharing I month suppry.

Indicate Copayment amount for Standard Retail \$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$84.00

7

PBP Data Report Page 38 of 43

Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$84.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$42.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$1.57

Daily Preferred Retail Copayment \$1.40

Daily Copayment for Long-Term Care \$1.35

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Brand
Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

Out-of-Network Pharmacy - one month supply

three month supply

month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

· Long Term Care Pharmacy - o

: Long Term Care Pharmacy - one month supply

: Standard Mail Order Cost-Sharing - three

SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

Patoil/Preferred Patoil Cost Sharing in your 1

Retail/Preferred Retail Cost-Sharing in your 1-month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

30

90

Yes

Yes





PBP Data Report Page 39 of 43

supply for the first fill?

SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

30

31

\$100.00

\$200.00

Indicate Copayment amount for Standard Retail

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$190.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$190.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$95.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$3.33

Daily Preferred Retail Copayment \$3.17

Daily Copayment for Long-Term Care \$3.06

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Specialty Tier

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Generic

: Brand

Indicate the type of cost-sharing structure: Coinsurance

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing -

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

PBP Data Report Page 40 of 43

Select all Out-of-Network Pharmacy

: Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing

Location/supply amount(s) that apply for this

Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

Tier:

: Long Term Care Pharmacy - one month supply

#### SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this

tier available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

supply for the first fill?



Yes

Yes

#### SECTION RX: TIER #5 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

#### SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

## SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard 25%

Retail Cost-Sharing 3-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred 25%

Retail Cost-Sharing 3-month supply:

#### SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

25%

Indicate Coinsurance percentage for Standard

Mail-Order Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of- 25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term 25%

PBP Data Report Page 41 of 43

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Generic : Brand

Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

Out-of-Network Pharmacy - one month supply

three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three

month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

supply for the first fill?

Yes

No

SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

Indicate Copayment amount for Standard Retail \$8.00

Contrato Número m

6/7/2021

about:blank

PBP Data Report Page 42 of 43

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail \$16.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$3.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail \$6.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail- \$6.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$8.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$3.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.27

Daily Preferred Retail Copayment \$0.10

Daily Copayment for Long-Term Care \$0.10

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD

How do you apply your cost sharing beyond the Medicare-defined Post Threshold Cost Shares

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX: TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Preferred Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 2

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Brand

apply):

Tier Includes: Part D Drugs Only

#1

PBP Data Report Page 43 of 43

Tier ID - OOP

#### SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Non-Preferred Brand

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that : Brand

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP 4

#### SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Specialty Tier

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that apply): : Generic : Brand

Tier Includes: Part D Drugs Only

Tier ID - OOP 5

#### SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Select Care Drugs

Select the type of drug benefit: Actuarially Equivalent Standard

Select drug type(s) in this Tier (select all that apply): : Generic : Brand

Tier Includes: Part D Drugs Only

Tier ID - OOP 6

#### **SECTION RX: VBID - GENERAL**

Are you offering Part D Benefits and/or Part D No

Rewards and Incentives under the VBID

Model?

S DE SALIO

# TRIPLE-S ADVANTAGE, INC.

# APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5774-035



Page 1 of 48

#### PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5774, PLAN 035, SEGMENT 0

Module: PBP Requested By: rzwg

PLAN SYSTEM INFORMATION

Last entry Date: 06/07/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/07/2021 04:22:52 PM SA Western Standard

Time

MA BPT Timestamp: 06/07/2021 03:54:45 PM SA Western Standard

Time

PD BPT Timestamp: 06/07/2021 04:04:03 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 06/07/2021 04:51:39 PM SA Western Standard

Time.

Upload Status: 06/07/2021 #02299

PLAN STATUS

Section A Status Plan Ready for Upload

Completed Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Section B6 Status Completed Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Section B12 Status Completed

Section B13 Status Completed
Section B14 Status Completed
Section B15 Status Completed
Section B16 Status Completed
Section B17 Status Completed

Section B18 Status Completed
Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

**SECTION A: SECTION A-1** 





Organization Legal Name:
Organization Marketing Name:
Organization Web Site:
Plan Name:
Organization Type:
Plan Type:
Enrollee Type:
Service Area(s):
d ' - A (a)

TRIPLE S ADVANTAGE, INC. Triple S Advantage www.sssadvantage.com Platino Alcance (HMO D-SNP) Local CCP **HMO** Part A and Part B 40010 - Adjuntas, PR 40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR

40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR





Service Area(s): 40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR 40390 - Lajas, PR 40400 - Lares, PR 40410 - Las Marias, PR 40420 - Las Piedras, PR 40430 - Loiza, PR 40440 - Luquillo, PR 40450 - Manati, PR 40460 - Maricao, PR 40470 - Maunabo, PR 40480 - Mayaguez, PR 40490 - Moca, PR 40500 - Morovis, PR 40510 - Naguabo, PR 40520 - Naranjito, PR 40530 - Orocovis, PR 40540 - Patillas, PR 40550 - Penuelas, PR 40560 - Ponce, PR 40570 - Quebradillas, PR 40580 - Rincon, PR 40590 - Rio Grande, PR 40610 - Sabana Grande, PR 40620 - Salinas, PR 40630 - San German, PR 40640 - San Juan, PR 40650 - San Lorenzo, PR 40660 - San Sebastian, PR 40670 - Santa Isabel, PR 40680 - Toa Alta, PR

40690 - Toa Baja, PR

40710 - Utuado, PR

40720 - Vega Alta, PR

40730 - Vega Baja, PR

40740 - Vieques, PR

40700 - Trujillo Alto, PR



Service Area(s):

	40750 - Villalba, PR	
Service Area(s):	40760 - Yabucoa, PR	
Service Area(s):	40770 - Yauco, PR	
Contract Number:	H5774	
Plan ID:	035	
Segment ID:	0	
Contract Period:	2022	
Plan Geographic Name:	Puerto Rico	
Is this an Employer-Only plan?	No	
SECTION A: SECTION A-2		
Indicate CY2022 total projected member	4608	
months for this plan:  Does this Plan have a CMS-approved	No	
Continuation Area?  Do you intend to participate in the PLATINO	Yes	
program?	Yes	
Is this a Special Needs Plan?	Dual-Eligible	
Special Needs Plan Type:	No No	
Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D Services)?	140	NOMINISTRYCIO
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No	Contrato Número m
SECTION A: SECTION A-3		E POS DE SALUD
Participating Pharmacy Website Address:	www.sssadvantage.com	SDESALO
Formulary Website Address:	www.sssadvantage.com	0.0
Physician Website Address:	www.sssadvantage.com	
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(888)620-1919	
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(888)620-1919	
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234	
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(833)221-2234	///
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919	$\mathcal{L}$
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(888)620-1919	
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(833)221-2234	Lear
SECTION A: SECTION A-4 Customer Service Contact Local Phone Number	(833)221-2234	11-

for Prospective Part D Medicare Beneficiaries:	m < 6 200 0500		
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520		
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)620-2520		
SECTION A: SECTION A-5			
Is your organization filing a standard bid for Section B of the PBP?	No		
Is your organization filing a standard bid for Section C of the PBP?	No		
SECTION A: SECTION A-6			
Is your organization filing a standard bid for Section D of the PBP?	No		
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1			
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	Yes		
Select enhanced benefits:	: Additional Days		
Select type of benefit for Additional Days:	Mandatory		
Is this benefit unlimited for Additional Days?	Yes		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2			
Is there a service-specific Maximum Enrollee	No		
Out-of-Pocket Cost?			
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No		
Is there an enrollee Coinsurance?	No		
SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 5			

Does this plan's Additional Days cost sharing

No







vary by hospital(s) in which an enrollee obtains care?

## SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7

No Is there an enrollee Deductible? No Is there an enrollee Copayment?

## SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12

Per Admission or Per Stay What is your Inpatient Hospital-Acute benefit period?

Do you charge cost sharing on the day of

No

discharge?

No Is authorization required? Is a referral required for Inpatient Hospital-No

Acute Services?

## SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

## SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2

Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee

obtains care?

No

No

No

### Is there an enrollee Coinsurance? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7

No Is there an enrollee Deductible? No Is there an enrollee Copayment?

## SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12

Per Admission or Per Stay What is your Inpatient Hospital Psychiatric benefit period?

No Do you charge cost sharing on the day of discharge?

No Is authorization required? Is a referral required for Inpatient Psychiatric No Hospital Services?

**SECTION B: #2 SNF - BASE 1** 

No Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay prior to SNF admission?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

SECTION B: #2 SNF - BASE 2



Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Per Admission or Per Stay

Do you charge cost sharing on the day of

discharge?

Is authorization required? Yes
Is a referral required for SNF Services? No

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1

No

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit under Part C?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2

Is there an enrollee Copayment?

Notes: Services in the USA may also be available

through reimbursement in accordance with Medicare rates and the location where services

were provided.

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2

Is there an enrollee Copayment? No SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 3

Notes:

Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

: Worldwide Emergency Coverage Select enhanced benefit:

: 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

Out-of-Pocket Cost?

Yes

Coverage?

Is the service-specific Maximum Plan Benefit

Coverage amount unlimited?

No

Indicate Maximum Plan Benefit Coverage

75.00

amount:

Is there a service-specific Maximum Enrollee

No

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No Is there an enrollee Deductible?

SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 3

Notes:

Worldwide services are covered through reimbursement in accordance with Triple-S

OSDESP

Advantage rates.

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No Yes Is authorization required? Is a referral required for Partial Hospitalization? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2



6/7/2021

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes

Is a referral required for Home Health Services? No

SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Care

Select type of benefit for Routine Care:

Is this benefit unlimited for Routine Care?

Mandatory

No, indicate number

Indicate number of visits for Routine Care: 5

Select Routine Care periodicity: Every year

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

Is authorization required?

Is a referral required for Chiropractic Services?

Yes

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2

Is authorization required? Yes
Is a referral required for Occupational Therapy No

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?







No Is there an enrollee Deductible? No Is there an enrollee Copayment?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2

Yes Is authorization required? Yes

Is a referral required for Physician Specialist

Services?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment?

SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3

No Is authorization required? No Is a referral required for Mental Health

Specialty Services - Non-Physician?

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a Yes

supplemental benefit under Part C?

: Routine Foot Care Select enhanced benefits:

Select type of benefit for Routine Foot Care: Mandatory

Is this benefit unlimited for Routine Foot Care? No Indicate number of Routine Foot Care visits: 4

Every year Select the Routine Foot Care periodicity:

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3

No Is authorization required? Is a referral required for Podiatrist Services? Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1

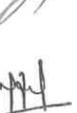
Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment?

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2





Is authorization required?

Is a referral required for Other Health Care

Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Is a referral required for Psychiatric Services?

No

SECTION B: #7I PT AND SP SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost?

Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2

Is authorization required? Yes

Is a referral required for Physical Therapy and

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1

Do you offer an Additional Telehealth benefit Yes

for Part B services?

Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services : 7d: Physician Specialist Services

: 7e1: Individual Sessions for Mental Health Specialty Services

: 7h1: Individual Sessions for Psychiatric

Services

No

No

: 14d: Kidney Disease Education Services : 14e2: Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

No

No

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3

Is authorization required for Additional

No

Telehealth Services?

Is a referral required for Additional Telehealth

Yes



DES

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 20

Is authorization required?

Is a referral required for Opioid Treatment

No

Program Services?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2

Is there an enrollee Coinsurance?

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3

Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic No

Procedures/Test/Lab Services?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Outpatient No

Diagnostic/Therapeutic Radiological, and X-

Ray Services?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes





Outpatient Hospital Services?

Is authorization required for Medicare-covered Yes

Observation Services?

Is a referral required for Medicare-covered No

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

No Is there an enrollee Deductible?

No Is there an enrollee Copayment?

Yes Is authorization required? No

Is a referral required for Ambulatory Surgical

Center Services?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

Is there an enrollee Copayment?

SECTION B: #9C OUTPATIENT SUBSTANCE ABUSE - BASE 3

No Is authorization required? Is a referral required for Outpatient Substance No

Abuse?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?

: Three (3) Pint Deductible Waived Select enhanced benefit:

Select type of benefit for Three (3) Pint Mandatory

Deductible Waived:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Is a referral required for Outpatient Blood No

Services?

6/7/2021





SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services

as a supplemental benefit under Part C?

Any Health-related Location Select enhanced benefit:

Yes

Mandatory Select type of benefit for Any Health-related

Location:

Is this benefit unlimited for number of trips for No

Any Health-related Location?

Indicate number of trips for Any Health-related 48

Location:

Select Any Health-related Location Trips Every year

periodicity:

Select Type of Transportation for Any Health-One-way

related Location:

Select Mode of Transportation for Any Health-: Taxi : Van related Location:

: Other, Describe

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance? Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

No Is there an enrollee Copayment? Yes Is authorization required? Is a referral required for Transportation No

Services?

Other methods of transportation are available, Notes:

such as an automobile through a contracted

provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No



Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	Yes
Indicate Minimum Coinsurance percentage for Medicare-covered Benefits:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Benefits:	5%
Medicare-covered beliefits.	3.7

Is there an enrollee Deductible? No No Is there an enrollee Copayment?

SECTION B: #11A DME - BASE 2

Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?

Is authorization required?

Notes:

Yes

Yes

0% coinsurance for preferred brands and

manufacturers.

5% coinsurance for non-preferred brands and

manufacturers.

## SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Yes

: Medicare-covered Prosthetic Devices Select which Prosthetics/Medical Supplies have : Medicare-covered Medical Supplies a Coinsurance (Select all that apply):

0% Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:

5% Indicate Maximum Coinsurance percentage for

Medicare-covered Prosthetic Devices: Indicate Minimum Coinsurance percentage for

Medicare-covered Medical Supplies:

Indicate Maximum Coinsurance percentage for

Medicare-covered Medical Supplies:

0%

5%

## SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2

No Is there an enrollee Deductible? No Is there an enrollee Copayment?

## SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3

Yes Is authorization required?

5% coinsurance applies to surgically implanted Notes: prosthetics devices, urinary system &

neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices. 0% coinsurance for preferred brand medical

supplies and manufacturers.

5% coinsurance for non-preferred brand medical

supplies and manufacturers.



SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2

Is there an enrollee Copayment? No
Do you limit Diabetic Supplies and Services to
Yes

those from specified manufacturers?

Is authorization required?

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Is a referral required for Dialysis Services? No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

Indicate limit for Number of Treatments: 12

Indicate Number of Treatments periodicity: Every year

ls there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

**SECTION B: #13A ACUPUNCTURE - BASE 3** 

Notes: Services are subject to the combined maximum limit with Alternative therapy benefit.

SECTION B: #13B OTC ITEMS - BASE 1





Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage periodicity:

Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?

Nicotine Replacement Therapy (NRT) Attestation:

#### **SECTION B: #13B OTC ITEMS - BASE 2**

Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?

Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?

SECTION B: #13B OTC ITEMS - BASE 3

Notes:

Yes

Mandatory

Yes

50.00

Every three months

No

No

Yes

: The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.

No

No

No

No

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

#### **SECTION B: #13C MEAL BENEFIT - BASE 1**

Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section. No

7

SECTION B: #14A MEDICARE-COVERED ZERO DOLLAR PREVENTIVE SERVICES

Medicare-covered Zero Dollar Preventive

Services Attestation

: I attest that there is no coinsurance, copayment, or deductible for all Original

Medicare preventive services that are offered at

zero dollar cost sharing.

Is authorization required?

Is a referral required?

No No

SECTION B: #14B ANNUAL PHYSICAL EXAM - BASE 1

Does the plan provide the Annual Physical

No

Exam as a supplemental benefit under Part C?

Select enhanced benefit (Select all that apply):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1

Does the plan provide Other Defined

Supplemental Benefits as a benefit under Part

C?

Yes

: 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:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory

Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit: Select type of benefit for Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Individual Sessions

No, indicate number

Mandatory

Select the type of Remote Access Technologies

offered (Select all that apply):

: Nursing Hotline

Select type of benefit for Counseling Services:

Mandatory

Yes

Is this benefit unlimited for Counseling

Services?

Individual Sessions

Indicate setting for Counseling Services: 20 Indicate duration of sessions (in minutes):

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 2

Select type of benefit for Alternative Therapies:

Is this benefit unlimited for Alternative

Therapies?

Mandatory

No, indicate number

Indicate number of visits offered for Alternative

Therapies:

12



SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 12

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 14

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management

by health educators.

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 15

Remote Access Technologies (Nursing Hotline)

OSDESP

Counseling Services Notes:

Notes:

Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate

available community services.

## SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16

Alternative Therapies Notes:\*



Services are subject to the combined maximum limit with Acupuncture benefits. Alternative Therapies include:

- · Chinese Medicine
- · Pranic Healing
- · Music Therapy
- · Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors, such as sleeping and learning disorders and communication issues)
- · Naturopathic Medicine
- Traditional Chinese Medicine
- Reflexology

### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

Is there an enrollee Coinsurance?

### SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2

No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Nο

Is a referral required for Kidney Disease

No

**Education Services?** 

## SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

## SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible?

## SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3

No Is there an enrollee Copayment? Is authorization required for Medicare-covered No

Glaucoma Screening?

No

Is authorization required for Medicare-covered

Diabetes Self-Management Training? Is authorization required for Medicare-covered

No

**Barium Enemas?** 

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

No

Is authorization required for Medicare-covered EKG following Welcome Visit?

## SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

No

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 1

Is there a Maximum Enrollee Out-of-Pocket No

Cost?

Is there an enrollee Coinsurance?

SECTION B: #15 MEDICARE PART B RX DRUGS - BASE 2

Is there an enrollee Copayment?

Is there an enrollee Deductible?

Is Authorization Required?

Does the plan offer step therapy?

No

Yes

Does the benefit step from (select all that apply):

Part B to Part B?
Part B to Part D?
Part D to Part B?

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a

mandatory supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Oral Exams

: Prophylaxis (Cleaning)

: Fluoride Treatment : Dental X-Rays

Yes

1

Select type of benefit for Oral Exams: Mandatory

Is this benefit unlimited for Oral Exams? No, indicate number

Indicate number of visits for Oral Exams: 1

Select the Oral Exams periodicity: Every six months

Select type of benefit for Prophylaxis Mandatory

(Cleaning):

Is this benefit unlimited for Prophylaxis No, indicate number

(Cleaning)?

Indicate number of visits for Prophylaxis 1

(Cleaning):

Select the Prophylaxis (Cleaning) periodicity: Every six months

Select type of benefit for Fluoride Treatment: Mandatory

Is this benefit unlimited for Fluoride Treatment? No, indicate number

Indicate number of visits for Fluoride

Treatment:

Select the Fluoride Treatment periodicity: Every six months

SECTION B: #16A PREVENTIVE DENTAL - BASE 2

Select type of benefit for Dental X-Rays: Mandatory

Is this benefit unlimited for Dental X-Rays? No, indicate number

Indicate number of visits for Dental X-Rays:

Select the Dental X-Rays periodicity: Other, Describe







Is there a service-specific Maximum Plan

No

Benefit Coverage amount?

SECTION B: #16A PREVENTIVE DENTAL - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #16A PREVENTIVE DENTAL - BASE 4

Is there an enrollee Deductible?

No No

Is there an enrollee Copayment?

SECTION B: #16A PREVENTIVE DENTAL - BASE 5

Is authorization required?

No

Is a referral required for Preventive Dental

Services?

No

Notes:

Up to (1) panoramic image or intraoral complete series including bitewings, every (3) 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, including up to (4) periapical and up to (2)

bitewings images per year.

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?

Select enhanced benefits:

Yes

: Non-routine Services

: Diagnostic Services

: Restorative Services

: Endodontics

: Periodontics

: Extractions

: Prosthodontics, Other Oral/Maxillofacial

Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine

Yes

Services?

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic

Yes

Services?

Select type of benefit for Restorative Services:

Mandatory

Is this benefit unlimited for Restorative

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Mandatory Select type of benefit for Endodontics:

Is this benefit unlimited for Endodontics?

Yes

Select type of benefit for Periodontics:

Mandatory





Contrato Númer

Is this benefit unlimited for Periodontics?

Yes

Select type of benefit for Extractions:

Mandatory

Is this benefit unlimited for Extractions?

Yes

Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:

Mandatory

Is this benefit unlimited for Prosthodontics,

Other Oral/Maxillofacial Surgery, Other

Yes

Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan

Yes

Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

Plan-specified amount per period

type:

Indicate Maximum Plan Benefit Coverage

4500.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance? No No Is there an enrollee Deductible?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Is a referral required for Comprehensive Dental Yes

No

Services?

Notes:

Services are administered with the periodicity established by the American Dental Association (ADA). Diagnostic services are not deducted from the annual maximum benefit limit and are administered with the periodicity established by the American Dental Association (ADA).

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental benefit under Part C?

Yes

Select enhanced benefit:

: Routine Eye Exams

: Other

Select type of benefit for Routine Eye Exams:

Mandatory

Is this benefit unlimited for Routine Eye

No, indicate number

Exams?

1

Indicate number of exams for Routine Eye

Every year

Select the Routine Eye Exams periodicity:

Enter name of Other Service:

Select type of benefit for Other Service:

Is this benefit unlimited for Other Service?

Indicate quantity for Other Service:

Select the Other Service periodicity:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance? Is there an enrollee Copayment? Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Is a referral required for Eye Exams?

Notes:

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental benefit under Part C?

Select enhanced benefits:

Select type of benefit for Contact lenses:

Is this benefit unlimited for Contact lenses?

Select type of benefit for Eyeglasses (lenses and

frames):

Is this benefit unlimited for Eyeglasses (lenses

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames: Is this benefit unlimited for Eyeglass frames?

Select type of benefit for Upgrades:

**SECTION B: #17B EYEWEAR - BASE 3** 

Is there a service-specific Maximum Plan

Eyewear eye exam

Mandatory

No, indicate number

Every year

No

No

No

No

No

No

No

The routine eye exam is the test performed by the physician to evaluate the need to have evewear. If evewear is needed, the plan will cover under the Other eye exam, consultation and prescription for eyewear including refraction.

Yes

: Contact lenses

: Eyeglasses (lenses and frames)

: Eyeglass lenses

: Eyeglass frames

: Upgrades

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes

Mandatory

Yes



Benefit Coverage amount?

Select the Maximum Plan Benefit Coverage

type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear? Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

**SECTION B: #17B EYEWEAR - BASE 5** 

Is there an enrollee Deductible? Is there an enrollee Copayment?

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? Is a referral required for Eyewear?

Notes:

Yes

SECTION B: #18A HEARING EXAMS - BASE 1 Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams

: Fitting/Evaluation for Hearing Aid

Select type of benefit for Routine Hearing

Exams:

Is this benefit unlimited for Routine Hearing

Exams?

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity: Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan No

Plan-specified amount per period

Yes

500.00

Every year

No

No

No

No

No

No

Routine eye exam: Test performed by physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eye exam, consultation and prescription for eyewear

DMINISTRAC

including refraction.

Mandatory

No, indicate number

Every year

Mandatory

No, indicate number

1

1

Every year



Benefit Coverage amount? No Is there an enrollee Deductible? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? No Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

No Is there an enrollee Copayment? No Is authorization required?

Is a referral required for Hearing Exams? No

SECTION B: #18B HEARING AIDS - BASE 1

Yes Does the plan provide Hearing Aids as a supplemental benefit under Part C?

: Hearing Aids (all types) Select enhanced benefits:

Mandatory Select type of benefit for Hearing Aids (all

types):

Is this benefit unlimited for Hearing Aids (all Yes

types)?

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

Both ears combined Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears combined?

Plan-specified amount per period Select the Maximum Plan Benefit Coverage

type:

Indicate Maximum Plan Benefit Coverage 1000.00

amount:

Indicate Maximum Plan Benefit Coverage Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

No Is there an enrollee Copayment? No Is there an enrollee Deductible?

SECTION B: #18B HEARING AIDS - BASE 5

No Is authorization required? Is a referral required for Hearing Aids? No

SECTION B: #19 VBID/MA UNIFORMITY FLEXIBILITY/SSBCI

Does your plan include MA Uniformity Yes

Flexibility with reductions in cost or additional

benefits?

Do you offer Special Supplemental Benefits for Yes







NISTRAC

OSDES

the Chronically Ill?

Select what type of benefit your SSBCI

includes:

Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in

Section Rx)

Yes No

#### SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more):

: Annual Wellness Visit

: Additional Benefits

: Medicare Health Risk Assessment

: Care Management Program : In-home Assessments

WHP Mode of Engagement (choose one or

more):

: Telephonic : In-Person

: Web-Based

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

No

No

Does your organization offer provider

incentives for offering or engaging beneficiaries

in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

: Electronic Health Records/Electronic Medical

Records

: Provider/Patient portals

: Health Information Exchanges

: Data Warehouses

Expected Number of Beneficiaries to be

Engaged Annually:

SECTION B: #19A REDUCTION IN COSTS VBID/UF/SSBCI

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C

reductions in cost?

No

318

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI

Does your VBID/MA Uniformity

Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional

3

Benefits contain? (1-15)

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE:

PACKAGE #1

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF:

PACKAGE #1

Which disease states does this benefit apply?

: Chronic Obstructive Pulmonary Disease

(COPD) (Select all that apply):

: Congestive Heart Failure (CHF)

: Other 1 : Other 2 : Other 3 : Other 4 : Other 5

Oncology Patients with Active Chemo by Other 1 Description:

Infusion or systemic radiotherapy

Acute Stroke Other 2 Description:

Hip, knee or open heart Surgery Other 3 Description:

COPD patients with supplemental o Other 4 Description:

dependency

Bedridden patients Other 5 Description: No

Does the enrollee need to have all diseases

selected to qualify?

Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.

No

No

#### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #1

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 14c: Other Defined Supplemental Benefits

#### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #1

Are any benefits exempt from the plan-level

No

deductible?

#### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #1

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #1

Notes:

Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's

home - Post Inpatient stay for Chronic Obstructive

Pulmonary Disease (COPD), with transition of

care to patient's home - Post Inpatient stay for Acute Stroke with

transition of care to patient's home

- Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

- Patients discharged from open heart surgery

6/7/2021



hip surgery or knee surgery with transition of care to patient's home

- COPD patients with supplemental oxygen dependency

- Bedridden patients

SECTION B: VBDVEVSSBC 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #1

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

**BASE 3: PACKAGE #1** 

Select type of benefit for In-Home Support

Mandatory

Services:

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #1

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #1

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 10: PACKAGE #1

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 12: PACKAGE #1

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 14: PACKAGE #1

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #1

In-Home Support Services Notes:\*

Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, and 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, (4) hours per day for a maximum of (12) days in the calendar year.

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #2

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

## SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - CHRONIC CONDITIONS: SSBCI: PACKAGE #2

To which chronic condition does this benefit apply? (Select all that apply):

: Chronic alcohol and other drug dependence

: Autoimmune disorders

: Cancer

: Cardiovascular disorders : Chronic heart failure

: Dementia : Diabetes

: End-stage liver disease

: End-stage renal disease (ESRD) : Severe hematologic disorders

: HIV/AIDS

: Chronic lung disorders

: Chro

No

Contrato Número

O

POS DE SAL

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #2

Is there a prerequisite for any additional benefits

for this package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 13i: Non-Primarily Health Related Benefits for

the Chronically III

: 14c: Other Defined Supplemental Benefits

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #2

Are any benefits exempt from the plan-level

No

deductible?

# SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #2

Are you offering retroactive reimbursement?

Is there a maximum benefit amount?

No No

### SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #2

Notes:

After member's clinical identification process, he/she will be sent a card with allowance for the purchase of food and groceries, grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants and of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Funds will be deposited once every quarter of the year while the member remains active in the plan.

### SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #2

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill

includes:

: Food and Produce

: Transportation for Non-Medical Needs

: General Supports for Living

#### SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 1: PACKAGE #2 Yes

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Select type of benefit for Food and Produce:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Mandatory

Yes

No

375.00

Every three years

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 2: PACKAGE #2

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Is a referral required for Food and Produce? No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #2

Notes:



Allowance is not cumulative and is restricted to the purchase of food and groceries and grocery delivery charges, combined with 13i General Supports for living (purchase of gasoline through contracted merchants and of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants) and with 14c Other Defined Supplemental Benefits (Thorough House Cleaning). 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, or cosmetics

### SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -**BASE 1: PACKAGE #2**

Yes

Does the plan provide Transportation for Non-

Medical Needs as a supplemental benefit under

Part C?

Any Location Select enhanced benefit: Mandatory Select type of benefit for Any Location: No

Is this benefit unlimited for number of trips for

Any Location?

0 Indicate number of trips for Any Location:

Every year Select Any Location Trips periodicity: Select Type of Transportation for Non-Medical One-way

Needs for Any Location:

Select Mode of Transportation for Non-Medical : Taxi : Van Needs for Any Location:

: Other, Describe



#### SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -BASE 2: PACKAGE #2

No Is there a service-specific Maximum Plan

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

No Is there an enrollee Coinsurance? No Is there an enrollee Deductible?

### SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS -**BASE 3: PACKAGE #2**

No Is there an enrollee Copayment? No Is authorization required? Is a referral required for Transportation for Non-No

Medical Needs?

Amount of trips is combined (not duplicated) Notes:

with the 10b trips for non-health related locations. Eligible members will have the flexibility of using transportation services to other locations such as churches, supermarkets

and financial institutions (i.e., banks).

### SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 1: PACKAGE #2

Does the plan provide General Supports for Yes

Living as a supplemental benefit under Part C? Select type of benefit for General Supports for Mandatory

Living:

Is there a service-specific Maximum Plan Yes

Benefit Coverage amount?

375.00 Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

Every three months

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

# SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for

Living?

# SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3; PACKAGE #2

Notes:



Allowance is not cumulative and is restricted to the purchase of gasoline through contracted merchants and payment of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants and is combined with 13i Food and Produce (Food and groceries and groceries delivery charges) and with 14c Other Defined Supplemental Benefits (Thorough House Cleaning).

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 1: PACKAGE #2

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3: PACKAGE #2

Select type of benefit for In-Home Support

Mandatory

Services:

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #2

Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined No

Supplemental Benefits?

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7: PACKAGE #2

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

#### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 10: PACKAGE #2

6/7/2021

Is there an enrollee Coinsurance?

No

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 12: PACKAGE #2

No Is there an enrollee Deductible? No Is there an enrollee Copayment?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -**BASE 14: PACKAGE #2** 

No Is authorization required? No Is a referral required for Other Defined

Supplemental Benefits?

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 16: PACKAGE #2

In-Home Support Services No



Allowance is not cumulative and is restricted to thorough house cleaning performed by a contracted professional and is combined with 13I Food and Produce (Food and groceries and groceries delivery charges) and with 13i General Supports for living (purchase of gasoline through contracted merchants and payment of utilities restricted to: water, electricity, internet, telephone, cable tv / satellite through contracted merchants).

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - PACKAGE TYPE: PACKAGE #3

Is this package applicable to VBID or MA

MA Uniformity Flexibility

Uniformity Flexibility or SSBCI?

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - DISEASE STATES: UF: PACKAGE #3

Which disease states does this benefit apply?

: Other 1

(Select all that apply):

Other 1 Description:

Bedridden patients with specific essential services requirements

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 1 (PACKAGE INFO): PACKAGE #3

Is there a prerequisite for any additional benefits No

for this package?

deductible?

Select all the Non-Medicare-covered additional

: 14c: Other Defined Supplemental Benefits

benefits offered in this package:

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 2 (OON/POS/PLAN-LEVEL DEDUCTIBLE): PACKAGE #3

Are any benefits exempt from the plan-level No

SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - BASE 3 (RETROACTIVE REIMBURSEMENT): PACKAGE #3

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? No



## SECTION B: #19B ADDITIONAL BENEFITS FOR VBID/UF/SSBCI - NOTES: PACKAGE #3

Notes:



Benefit is limited to bedridden patients with essential services requirements limited to

- -Chemotherapy
- -Oxygen dependency
- -Ventilator
- -Enteral Nutrition
- -Specialty drugs (cancer/pulmonary hypertension)
- -CPAP
- -Wound Care
- -Ostomized

Besides having the eligible condition, member must meet with care manager at least once every quarter in order to have access to the benefit.

#### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 1: PACKAGE #3

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

Select enhanced benefit (Select all that apply):

: 14c21: In-Home Support Services\*

SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 3: PACKAGE #3

Select type of benefit for In-Home Support

Mandatory

Services:

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4: PACKAGE #3

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

#### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -BASE 7: PACKAGE #3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 10: PACKAGE #3

Is there an enrollee Coinsurance?

No

### SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFIT

BASE 12: PACKAGE #3

No

Is there an enrollee Deductible?
Is there an enrollee Copayment?

No

## SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS -

BASE 14: PACKAGE #3

No

Is authorization required?

Is a referral required for Other Defined

No

Supplemental Benefits?

74

# SECTION B: VBID/UF/SSBCI 19B #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 16: PACKAGE #3

In-Home Support Services Notes:\*



After meeting with the care manager once every quarter, the benefit will be available in blocks of 40 hours per quarter (not cumulative) for a maximum of 160 hours per year. Benefit consists of In-home Support for activities of daily living such as: Help with bathing and dressing, transferring or mobility help, light housekeeping (cleaning, laundry, dishes), meal preparation, medication reminders, noninvasive / non-clinical care such as diaper change or patient rotation to avoid ulcers, documentation and reporting back to the plan, coordinate doctor visits, plan coverage navigation to order refills and coordinate delivery using technology and escalation process to attend particular needs. 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.

SECTION B: #19C VBID HOSPICE- BASE 1

Is there an enrollee Coinsurance? No
Is there an enrollee Coinsurance? No
SECTION B: #19C VBID HOSPICE- BASE 2

Is there an enrollee Coinsurance? No

### SECTION B: #19C VBID HOSPICE- BASE 3

Are you offering hospice supplemental benefits? Yes

Is there a max plan benefit amount?

Are hospice supplemental benefits contingent

upon receiving services from an in-network provider?

Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.

Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.

Reduced cost sharing for unrelated medical care services received during hospice election

Yes

No

No

No



Other mandatory supplemental benefits Describe other mandatory supplemental

benefits:

SECTION B: #19C VBID HOSPICE- BASE 4

Hospice notes



Yes In-Home Support

In-Home Support Benefit consisting of assistance by qualified staff for activities of daily living, such as help with bathing and dressing, transfer or assistance for mobility, light housekeeping (cleaning, laundry, dishes), meal preparation and medication reminders. One 4-hour visit per week as long as the member participates in the hospice program with a contracted in-network provider. There is no cost-sharing or copayment for drugs and biologicals or inpatient respite care for both innetwork and out-of-network hospice benefits.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

SECTION D: MAX ENROLLEE COST LIMIT (IN-NETWORK)

Is there an In-Network Maximum Enrollee Out-

of-Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

3400.00

: In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Outof-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Yes

#### SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your pharmacy

network (select all that apply):

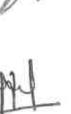
Actuarially Equivalent Standard

: Standard/Preferred Retail

: Out-of-Network

: Standard Mail-Order

: Long-Term Care



Sponsor attests that it will comply with 42 CFR 423.154.

: Sponsor attests that it will comply with 42 CFR 423.154.

#### SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? Does plan utilize ceiling pricing?

Do you pay for over-the-counter medications (OTCs) under the utilization management program?

OTC Medication Attestation statement

Yes No Yes

4

No

: Per Chapter 4 of the Medicare Managed Care Manual, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.

#### SECTION RX: MEDICARE RX GENERAL 3

Indicate number of Tiers in your Part D benefit: 6 What is your Formulary Exceptions Tier? Do you apply a second less expensive costsharing level for all generic drugs approved for

#### formulary exceptions? SECTION RX: MEDICARE RX - TIER MODEL

Indicate Formulary Tier Label Model (Click to select):

Preferred Generic, Generic, Preferred Brans Non-Preferred Brand, Specialty Tier, Select Care Drugs

## SECTION RX: ACTUARIALLY EQUIVALENT CHARACTERISTICS

Indicate the Out-of-Network (OON) costsharing structure for this plan:

Standard Retail Copay/Coinsurance plus a differential between the OON billed charge and the Standard Retail allowable\*\*

#### SECTION RX: ACTUARIALLY EQUIVALENT - PRE-ICL Cost Share Tiers

How do you apply your cost sharing before the Initial Coverage Limit (ICL) is reached?

#### SECTION RX: TIER #1 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL Preferred Generic

Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): Copayment

Indicate the type of cost-sharing structure: SECTION RX: TIER #1 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing three month supply

: Out-of-Network Pharmacy - one month supply





Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three

month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this

: Long Term Care Pharmacy - one month supply

Tier:

#### SECTION RX: TIER #1 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

Yes

90

No

90

30

31

SECTION RX: TIER #1 - MAIL-ORDER LOCATION SUPPLY - PRI

Enter number of days for Standard Mail-Order

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #1 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

SECTION RX: TIER #1 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail \$19.00

Cost-Sharing 1-month supply:

\$38.00 Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail \$14.00

Cost-Sharing 1-month supply:

\$28.00 Indicate Copayment amount for Preferred Retail

Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

\$28.00 Indicate Copayment amount for Standard Mail-

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #1 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-I

Indicate Copayment amount for Out-of-Network \$19.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$14.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #1 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-IC

Daily Standard Retail Copayment \$0.63

Daily Preferred Retail Copayment \$0.47

Daily Copayment for Long-Term Care \$0.45

Pharmacy

SECTION RX: TIER #2 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description Generic

Select the type of drug benefit: Actuarially Equivalent Standard

Tier Includes: Part D Drugs Only

Tier Drug type(s) (select all that apply): : Generic
Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #2 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing - one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply: Out-of-Network Pharmacy - one month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier: : Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #2 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard 30

Retail/Preferred Retail Cost-Sharing in your 1-month supply:

Enter number of days for Standard 90

Retail/Preferred Retail Cost-Sharing in your 3-month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

Yes

No

supply for the first fill?

SECTION RX: TIER #2 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order 90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #2 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network 30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

SECTION RX: TIER #2 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE

ICL

Indicate Copayment amount for Standard Retail \$20.00 Cost-Sharing 1-month supply: Indicate Copayment amount for Standard Retail \$40.00 Cost-Sharing 3-month supply: Indicate Copayment amount for Preferred Retail \$15.00 Cost-Sharing 1-month supply: Indicate Copayment amount for Preferred Retail \$30.00



SECTION RX: TIER #2 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-\$30.00

Order Cost-Sharing 3-month supply:

Cost-Sharing 3-month supply:

SECTION RX: TIER #2 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$20.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term \$15.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #2 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

\$0.67 Daily Standard Retail Copayment \$0.50 Daily Preferred Retail Copayment \$0.48 Daily Copayment for Long-Term Care

Pharmacy

SECTION RX: TIER #3 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Brand Tier Drug type(s) (select all that apply): Indicate the type of cost-sharing structure: Copayment

SECTION RX: TIER #3 - TIER LOCATIONS - PRE-ICL

: Standard Retail/Preferred Retail Cost-Sharing -Select all Standard Retail/Preferred Retail Costone month supply Sharing Pharmacy Location/supply amount(s)

: Standard Retail/Preferred Retail Cost-Sharing that apply for this Tier: three month supply

: Out-of-Network Pharmacy - one month supply Select all Out-of-Network Pharmacy Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this

Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #3 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1-



month supply:

90 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Yes

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

No

G

supply for the first fill?

POSDESA SECTION RX: TIER #3 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #3 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #3 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$47.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$94.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$42.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$84,00

Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$84.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #3 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network \$47.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$42.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #3 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

\$1.57 Daily Standard Retail Copayment \$1.40 Daily Preferred Retail Copayment \$1.35 Daily Copayment for Long-Term Care

Pharmacy

SECTION RX: TIER #4 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Brand Tier Drug type(s) (select all that apply):

Indicate the type of cost-sharing structure:

Copayment

#### SECTION RX: TIER #4 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing three month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

: Out-of-Network Pharmacy - one month supply

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

: Standard Mail Order Cost-Sharing - three month supply

Select all Long-Term Care Pharmacy

Location/supply amount(s) that apply for this Tier:

: Long Term Care Pharmacy - one month supply

### SECTION RX: TIER #4 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 1month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Yes

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month

Yes

supply for the first fill?

### SECTION RX: TIER #4 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

#### SECTION RX: TIER #4 - OON AND LTC LOCATION SUPPLY - PRE-ICL 30

Enter number of days for Out-of-Network

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

#### SECTION RX: TIER #4 - RETAIL PHARMACY COPAYMENT AND COINSURANCE ICL

Indicate Copayment amount for Standard Retail \$100.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

Cost-Sharing 3-month supply:

\$200.00

Indicate Copayment amount for Preferred Retail

\$95.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$190.00

Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$190.00

Order Cost-Sharing 3-month supply:

SECTION RX: TIER #4 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$100.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$95.00

Care Pharmacy 1-month supply:

SECTION RX: TIER #4 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

\$3.33 Daily Standard Retail Copayment \$3.17 Daily Preferred Retail Copayment \$3.06 Daily Copayment for Long-Term Care

Pharmacy

SECTION RX: TIER #5 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Part D Drugs Only Tier Includes:

: Generic Tier Drug type(s) (select all that apply): : Brand

Coinsurance Indicate the type of cost-sharing structure:

SECTION RX: TIER #5 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s)

that apply for this Tier:

: Standard Retail/Preferred Retail

one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month supply

SECTION RX: TIER #5 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

30 Enter number of days for Standard Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

Retail/Preferred Retail Cost-Sharing in your 3month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Are any of the drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?

90

Yes

Yes



SECTION RX: TIER #5 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

SECTION RX: TIER #5 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

SECTION RX: TIER #5 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-

ICL

25% Indicate Coinsurance percentage for Standard Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Standard

25%

Retail Cost-Sharing 3-month supply:

25%

Indicate Coinsurance percentage for Preferred Retail Cost-Sharing 1-month supply:

Indicate Coinsurance percentage for Preferred

25%

Retail Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Standard

25%

Mail-Order Cost-Sharing 3-month supply:

SECTION RX: TIER #5 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Coinsurance percentage for Out-of-

25%

Network Pharmacy 1-month supply:

Indicate Coinsurance percentage for Long-Term

25%

Care Pharmacy 1-month supply:

SECTION RX; TIER #6 - TIER TYPE AND COST-SHARE STRUCTURE - PRE-ICL

Tier Label Description

Select Care Drugs

Select the type of drug benefit:

Actuarially Equivalent Standard

Tier Includes:

Part D Drugs Only

Tier Drug type(s) (select all that apply):

: Generic

: Brand

Indicate the type of cost-sharing structure:

Copayment

SECTION RX: TIER #6 - TIER LOCATIONS - PRE-ICL

Select all Standard Retail/Preferred Retail Cost-Sharing Pharmacy Location/supply amount(s) that apply for this Tier:

: Standard Retail/Preferred Retail Cost-Sharing one month supply

: Standard Retail/Preferred Retail Cost-Sharing -

three month supply

: Out-of-Network Pharmacy - one month supply

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply for this

Tier:

Select all Standard Mail-Order Cost-Sharing Location/supply amount(s) that apply for this Tier (Optional):

Select all Long-Term Care Pharmacy

: Standard Mail Order Cost-Sharing - three month supply

: Long Term Care Pharmacy - one month suppl

Location/supply amount(s) that apply for this

Tier:

#### SECTION RX: TIER #6 - RETAIL PHARMACY LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard

30

Retail/Preferred Retail Cost-Sharing in your 1-

month supply:

Enter number of days for Standard

90

Retail/Preferred Retail Cost-Sharing in your 3-

month supply:

Are all of the drugs on your formulary for this tier available with an extended day supply?

Yes

m

OSDESP

ther available with an extended day supply?

Are any of the drugs available at an extended

day supply for this tier limited to a 1-month

day supply for this tier limited to a 1-supply for the first fill?

No

### SECTION RX: TIER #6 - MAIL-ORDER LOCATION SUPPLY - PRE-ICL

Enter number of days for Standard Mail-Order

90

Cost-Sharing in your 3-month supply:

### SECTION RX: TIER #6 - OON AND LTC LOCATION SUPPLY - PRE-ICL

Enter number of days for Out-of-Network

30

Pharmacy in your 1-month supply:

Enter number of days for Long-Term Care

31

Pharmacy 1-month supply:

# SECTION RX: TIER #6 - RETAIL PHARMACY COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Retail

\$10.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Standard Retail

\$20.00

Cost-Sharing 3-month supply:

Indicate Copayment amount for Preferred Retail

\$3.00

Cost-Sharing 1-month supply:

Indicate Copayment amount for Preferred Retail

\$6.00

Cost-Sharing 3-month supply:

## SECTION RX: TIER #6 - MAIL-ORDER COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Standard Mail-

\$6.00

Order Cost-Sharing 3-month supply:

### SECTION RX: TIER #6 - OON AND LTC COPAYMENT AND COINSURANCE - PRE-ICL

Indicate Copayment amount for Out-of-Network

\$10.00

Pharmacy 1-month supply:

Indicate Copayment Amount for Long-Term

\$3.00

Care Pharmacy 1-month supply:

### SECTION RX: TIER #6 - DAILY COPAYMENT AMOUNT COST-SHARING - PRE-ICL

Daily Standard Retail Copayment \$0.33

Daily Preferred Retail Copayment \$0.10

Daily Copayment for Long-Term Care \$0.10

Pharmacy

SECTION RX: ACTUARIALLY EQUIVALENT - OOP THRESHOLD Medicare-defined Post Threshold Cost Shares

How do you apply your cost sharing beyond the

Medicare Part D Annual Out-of-Pocket Cost

Threshold?

SECTION RX; TIER #1 - TIER TYPE - POST-OOP THRESHOLD

Preferred Generic Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic

Select drug type(s) in this Tier (select all that

apply):

Part D Drugs Only Tier Includes:

Tier ID - OOP

SECTION RX; TIER #2 - TIER TYPE - POST-OOP THRESHOLD

Tier Label Description Generic

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Generic

apply):

Tier Includes: Part D Drugs Only

Tier ID - OOP

SECTION RX: TIER #3 - TIER TYPE - POST-OOP THRESHOLD

Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

3 Tier ID - OOP

SECTION RX: TIER #4 - TIER TYPE - POST-OOP THRESHOLD

Non-Preferred Brand Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

Select drug type(s) in this Tier (select all that : Brand

apply):

Part D Drugs Only Tier Includes:

4 Tier ID - OOP

SECTION RX: TIER #5 - TIER TYPE - POST-OOP THRESHOLD

Specialty Tier Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic

Select drug type(s) in this Tier (select all that : Brand apply):

Part D Drugs Only Tier Includes:

5 Tier ID - OOP

SECTION RX: TIER #6 - TIER TYPE - POST-OOP THRESHOLD

Select Care Drugs Tier Label Description

Actuarially Equivalent Standard Select the type of drug benefit:

: Generic Select drug type(s) in this Tier (select all that

apply):

Tier Includes:

Tier ID - OOP

**SECTION RX: VBID - GENERAL** 

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID

Model?

: Brand

Part D Drugs Only

-6

No



714