APPENDIX C (1)

Medicare Advantage Plan

Benefit Package PBP

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

040 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Selecto (HMO D-SNP)	Platino Selecto

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?

Yes

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Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No

EMR

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

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Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

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Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

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Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)	Required	Mandatory
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)		
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

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Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)		
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear Eye Exam(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

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Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

No

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

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Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes

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Services	In-Network
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes

Services	In-Network
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	

EMR

Services	In-Network
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)

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Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)
Other Health Care Professional(7g)

Referral

Is referral required for any In-Network service categories?

No

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

VBID

Does this plan offer VBID hospice benefits?

Yes

EMR

Does this plan offer Part C benefits under the VBID model?

Yes

Select benefits:

Value-based design flexibilities by condition or socioeconomic state,

I attest that: TRUE

1) the benefits entered comply with CMS required for benefits offered in the VBID model
2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID Model, unless otherwise approved by CMS in writing, and
3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment
Care Management Program
In-home Assessments

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

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Enter the Expected Number of Beneficiaries to be Engaged Annually

3182

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

Other, Describe

Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

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No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

Select the type(s) of hospice supplemental benefits offered

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

Package ID	Package Name	Type of Package	Status
1	Package 1	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Chronic Obstructive Pulmonary Disease (COPD),
Congestive Heart Failure (CHF),
Other 1,
Other 2,
Other 3,
Other 4,
Other 5

Other 1 Description

Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

Other 2 Description

Acute Stroke

Other 3 Description

Abdominal, Hip, knee or open heart surgery

Other 4 Description

COPD patients with supplemental oxygen dependency

Other 5 Description

Bedridden patients

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

Notes

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Package ID	Package Name	Type of Package	Status

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, abdominal surgery, hip surgery or knee surgery with transition of care to patient's home - COPD patients with supplemental oxygen dependency - Bedridden patients

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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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 120 hours of care in a calendar year, (4) hours per day for a maximum of (30) days in the calendar year.

2	Package 2	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Other 1

EMR

Other 1 Description

Package ID	Package Name	Type of Package	Status

Bedridden patients with specific essential services requirements

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

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

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

EMR

Package ID	Package Name	Type of Package	Status

No

Referral required for this benefit?

No

Notes

After meeting with the care manager once every quarter, the benefit will be available in blocks of 60 hours per quarter (not cumulative) for a maximum of 240 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, non-invasive / nonclinical 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.

3	Package 3	VBID	Completed

Select Target Methodology (Required)

Socioeconomic Status,

Expected Number of Enrollees to be Targeted

4611

Expected Number of Enrollees to be engaged and receive Model benefits

4611

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
General Supports for Living (13i10),
Food and Produce (13i1),
Social Needs Benefit (13i6)

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Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

$40.00

EMR

Periodicity

Package ID	Package Name	Type of Package	Status

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

Select all the Non-Medicare-covered benefits that apply to the package level maximum coverage

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
Social Needs Benefit (13i6),
General Supports for Living (13i10)

Notes

Members will be sent a card with an allowance for the purchase of food, groceries cleaning products, allowed OTC items (besides the OTC Benefit included in section 13b), grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants, access to cultural, social and entertainment events, copays and coinsurances, additional transportation (besides the transportation benefit in section 10b) and for utilities restricted to: propane gas, water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Benefit is cumulative and funds will be deposited once every month of the year while the member remains active in the plan.

Package Selected Benefit Details

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

Yes

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

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EMR

Package ID	Package Name	Type of Package	Status

$40.00

Periodicity

Every Month

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Other methods of transportation are available, such as an automobile through a contracted provider.

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$40.00

Periodicity

Every Month

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

Yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

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Package ID	Package Name	Type of Package	Status

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Notes

Allowance is cumulative and is restricted to the purchase of allowed OTC items (besides the OTC Benefit included in section 13b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$40.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Package ID	Package Name	Type of Package	Status

No

Notes

Allowance is cumulative and is restricted to the purchase of food and groceries and grocery delivery charges combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$40.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to access to cultural, social and entertainment events combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

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Package ID	Package Name	Type of Package	Status

$40.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is 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, thorough housecleaning performed by a professional and cleaning products combined with all other VBID Flexible (by Socioeconomic Status) benefits.

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Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

EMR

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

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Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

EMR

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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EMR

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

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Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

EMR

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

EMR

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

Yes

EMR

Authorization required for this benefit?

Yes

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

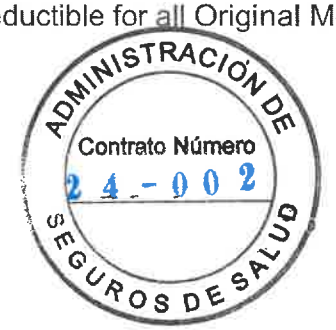
true

Authorization required for this benefit?

No

Referral required for this benefit?

No



EMR

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

EMR

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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Authorization required for this benefit?

No

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

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Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

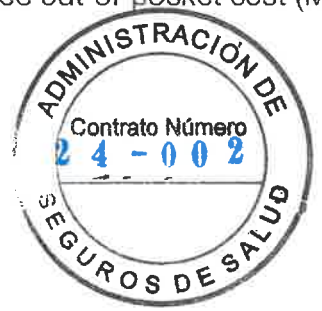
No

Is there a coinsurance?

No

Is there a copayment?

No



Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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No

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

18

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$50.00

Periodicity

Every 3 Months

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

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Notes

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Covid-19 tests, Dermatologicals, First Aid supplies, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Mouth care, Multivitamins, Naloxone product, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Optic Agents, Supportive items for comfort, Topical Sunscreen, Urinary Analgesics, Vaginal Products, Vitamins, Weight loss items, Adult Diapers/Pads and Blood Pressure Monitor. Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

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Is this benefit unlimited?

No

Indicate number of visits

12

Setting

Individual Sessions

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Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Number of visits

Individual Sessions

Session duration (in minutes):

20

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$5000.00

Periodicity

Every Year

Is there a deductible?

No

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Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

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No

Notes

(Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6 months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year. Diagnostic services are not deducted from the annual maximum benefit limit. Comprehensive oral evaluation

Restorative Services (16b3) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond

Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

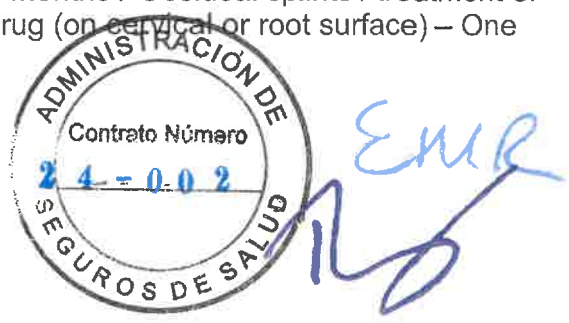
Yes

Referral required for this benefit?

No

Notes

Complete or partial maxillary and mandibular denture including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months. /



Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear Eye Exam (17a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$1000.00

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a deductible?

No

Is there a maximum plan benefit coverage?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$3000.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

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Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

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Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$11.00

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Daily Copayment 1-month

$0.37

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$22.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$22.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$11.00

Daily Copayment 1-month

$0.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$16.00

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Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 2 - Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

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Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$12.00

Daily Copayment 1-month

$0.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$24.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$24.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$12.00

Daily Copayment 1-month

$0.39

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$17.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

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Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

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30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$94.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

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Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.17

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

ADMINISTRACION DE SEGUROS DE SALUD
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EMR

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$100.00

Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

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90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

ADMINISTRACIÓN DE SEGUROS DE SALUD
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90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$7.00

Daily Copayment 1-month

$0.23

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$14.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$14.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$7.00

Daily Copayment 1-month

$0.23

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$8.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Insulin

Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply

$8.00

Copayment 3-month supply

$16.00

Preferred Retail

Copayment 1-month supply

$7.00

Copayment 3-month supply

$14.00

Standard Mail-Order

Copayment 3-month supply

$14.00

Long-Term Care

Copayment 1-month supply

$7.00

Out-of-Network

Copayment 1-month supply

$8.00

Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

ADMINISTRACIÓN DE SEGUROS DE SALUD
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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

036 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Titan (HMO D-SNP)	Puerto Rico

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?

Yes

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Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No

EMR

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

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Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

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Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

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EMR

Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

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Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)	Required	Mandatory
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

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Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear exams(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

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Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

EMR

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes

EMR

Services	In-Network
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes

EMR

Services	In-Network
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	

EMR

Services	In-Network
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

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Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)

EMR

Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)
Other Health Care Professional(7g)

Referral

Is referral required for any In-Network service categories?

No

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
Combined Supplemental Benefits 1	Other	No	N/A	12 - Every Year	Completed

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

Acupuncture - Number of Treatments(13a)

Alternative Therapies(14c17)

EMR

Name of Other Delivery:

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
	network provider				

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

VBID

Does this plan offer VBID hospice benefits?

Yes

Does this plan offer Part C benefits under the VBID model?

Yes

Select benefits:

Value-based design flexibilities by condition or socioeconomic state,

I attest that: TRUE

1) the benefits entered comply with CMS required for benefits offered in the VBID model
2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID Model, unless otherwise approved by CMS in writing, and
3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment

EMR

Care Management Program
In-home Assessments

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

Enter the Expected Number of Beneficiaries to be Engaged Annually

17868

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

EMR

Other, Describe

Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

Select the type(s) of hospice supplemental benefits offered

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

Package ID	Package Name	Type of Package	Status
1	Package #1	VBID	Completed

Select Target Methodology (Required)

Socioeconomic Status,

Expected Number of Enrollees to be Targeted

25895

Expected Number of Enrollees to be engaged and receive Model benefits

25895

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Package ID	Package Name	Type of Package	Status

Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
General Supports for Living (13i10),
Social Needs Benefit (13i6),
Transportation Services - Any Health-related Location (10b2)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

$75.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

Select all the Non-Medicare-covered benefits that apply to the package level maximum coverage

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
Social Needs Benefit (13i6),
General Supports for Living (13i10)

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Notes

Members will be sent a card with an allowance for the purchase of food, groceries cleaning products, allowed OTC items (besides the OTC Benefit included in section 13b), grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants, access to cultural, social and entertainment events, copays and coinsurances, additional transportation (besides the transportation benefit in section 10b) and for utilities restricted to: propane gas, water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Benefit is cumulative and funds will be deposited once every month of the year while the member remains active in the plan.

Package Selected Benefit Details

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

Yes

Type of transportation

One-Way

EMR

Package ID	Package Name	Type of Package	Status

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$75.00

Periodicity

Every Month

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Notes

Allowance is cumulative and is restricted additional transportation to medical destinations (medical appointments in any medical facility, preventive services activities, and picking up prescriptions at pharmacies) through contracted vendors (besides the transportation benefit in section 10b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

Package ID	Package Name	Type of Package	Status

$75.00

Periodicity

Every Month

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

Yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Notes

Allowance is cumulative and is restricted to the purchase of allowed OTC items (besides the OTC Benefit included in section 13b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$75.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

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Package ID	Package Name	Type of Package	Status

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to the purchase of food and groceries and grocery delivery charges combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$75.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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Package ID	Package Name	Type of Package	Status

No

Notes

Allowance is cumulative and is restricted to access to cultural, social and entertainment events combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$75.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is 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, thorough housecleaning performed by a professional and cleaning products combined with all other VBID Flexible (by Socioeconomic Status) benefits

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Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

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Referral required for this benefit?

No

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EMR

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

Yes

Copayment amount

$2.00

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

EMR

Referral required for this benefit?

No

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

Yes with a min & max

Minimum copayment	Maximum copayment
$0.00	$2.00

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

$0 copay for services rendered in SALUS facility. $2 copay for services rendered in the provider network.

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

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Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

EMR

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

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Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

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EMR

No

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Is there a deductible?

No

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

Yes

Authorization required for this benefit?

Yes

Notes

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

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

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 and Cardiovascular Devices.

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

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

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

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Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

true

Authorization required for this benefit?

No

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

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EMR

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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Authorization required for this benefit?

No

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

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EMR

Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

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Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

EMR

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

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No

Is there a copayment?

Yes

Copayment amount

$2.00

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

Yes with a min & max

Minimum copayment	Maximum copayment
$0.00	$2.00

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

$0 copay for services rendered in SALUS facility. $2 copay for services rendered in the provider network.

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

48

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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EMR

Notes

Benefit is limited to 24 one-way trips per year to healthcare related destinations and additional 2 one-way noncumulative trips per month to preferred contracted multidisciplinary clinics (max. of 24 per year) for a total of up to 48 one-way trips per year.

Acupuncture - Number of Treatments (13a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

12

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$50.00

Periodicity

Every 3 Months

EMR

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Notes

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Covid-19 tests, Dermatologicals, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Multivitamins, Naloxone product, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Optic 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.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

EMR

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Setting

Individual Sessions

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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No

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Number of visits

Individual Sessions

Session duration (in minutes):

20

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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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

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$2000.00

Periodicity

Every Year

Is there a deductible?

No

Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Comprehensive oral evaluation – (Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6 months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year. Diagnostic services are not deducted from the annual maximum benefit limit.

Restorative Services (16b3) - Non-Medicare

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Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond

Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Root Gingival flap procedure – One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Complete or partial maxillary and mandibular denture including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months.

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

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.

Eyewear exams (17a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$500.00

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EMR

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a deductible?

No

Is there a maximum plan benefit coverage?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

EMR

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1000.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

EMR

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

EMR

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

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Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$19.00

Daily Copayment 1-month

$0.63

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$38.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.52

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$19.00

Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

EMR

Rx Tier 2 - Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$20.00

Daily Copayment 1-month

$0.67

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$40.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.55

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$20.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

EMR

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$94.00

Preferred Retail

ADMINISTRACIÓN DE SEGUROS DE SALUD
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24-002

EMR

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.35

Out of Network

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EMR

Select days for out of network 1-month supply

30

Copayment 1-month supply

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

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EMR

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.17

3-Month Supply

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EMR

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$100.00

EMR

Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

EMR

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

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Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

EMR

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$9.00

Daily Copayment 1-month

$0.30

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$18.00

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EMR

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.26

ADMINISTRACIÓN DE SEGUROS DE SALUD
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EMR

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$9.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Insulin

Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply
$9.00

Copayment 3-month supply
$18.00

Preferred Retail

Copayment 1-month supply
$8.00

Copayment 3-month supply
$16.00

Standard Mail-Order

Copayment 3-month supply
$16.00

Long-Term Care

Copayment 1-month supply
$8.00

Out-of-Network

Copayment 1-month supply
$9.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

EMR

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?
No

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

035 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Enlace (HMO D-SNP)	Puerto Rico

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?

Yes

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 2024-002

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No

EMR

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
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EMR

Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

EMR

Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)		
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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EMR

Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear Exam(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

ADMINISTRACIÓN DE SEGUROS DE SALUD
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Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

EMR

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes

EMR

Services	In-Network
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes

EMR

Services	In-Network
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	

EMR

Services	In-Network
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)

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Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)
Other Health Care Professional(7g)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Chiropractic Services(7b)
Physician Specialist Services(7d)
Podiatry Services(7f)
Other Health Care Professional(7g)
Additional Telehealth Benefits(7j)
Routine Chiropractic Care(7b1)
Podiatry Services: Routine Foot Care(7f)

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
Combined Supplemental	Other	No	N/A	12 - Every Year	Completed

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status

Benefits 1

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

Acupuncture - Number of Treatments(13a)

Alternative Therapies(14c17)

Name of Other Delivery:

Network provider

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

VBID

Does this plan offer VBID hospice benefits?

Yes

Does this plan offer Part C benefits under the VBID model?

Yes

Select benefits:

Value-based design flexibilities by condition or socioeconomic state,

I attest that: TRUE

1) the benefits entered comply with CMS required for benefits offered in the VBID model
2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID Model, unless otherwise approved by CMS in writing, and
3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

No

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

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VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment
Care Management Program
In-home Assessments

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

Enter the Expected Number of Beneficiaries to be Engaged Annually

563

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

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Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

Other, Describe

Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

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Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

Select the type(s) of hospice supplemental benefits offered

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

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VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

EMR

Package ID	Package Name	Type of Package	Status
1	Package 1	VBID	Completed

Select Target Methodology (Required)

Socioeconomic Status,

Expected Number of Enrollees to be Targeted

816

Package ID	Package Name	Type of Package	Status

Expected Number of Enrollees to be engaged and receive Model benefits

816

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Over-the-Counter (OTC) Items (13b),
General Supports for Living (13i10),
Food and Produce (13i1),
Social Needs Benefit (13i6),
Transportation Services - Any Health-related Location (10b2)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

$150.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

Select all the Non-Medicare-covered benefits that apply to the package level maximum coverage

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
Social Needs Benefit (13i6),
General Supports for Living (13i10)

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Notes

Members will be sent a card with an allowance for the purchase of food, groceries cleaning products, allowed OTC items (besides the OTC Benefit included in section 13b), grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants, access to cultural, social and entertainment events, copays and coinsurances, additional transportation (besides the transportation benefit in section 10b) and for utilities restricted to: propane gas, water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Benefit is cumulative and funds will be deposited once every month of the year while the member remains active in the plan.

Package Selected Benefit Details

Package ID	Package Name	Type of Package	Status

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

Yes

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$150.00

Periodicity

Every Month

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted additional transportation to medical destinations (medical appointments in any medical facility, preventive services activities, and picking up

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Package ID	Package Name	Type of Package	Status

prescriptions at pharmacies) through contracted vendors (besides the transportation benefit in section 10b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$150.00

Periodicity

Every Month

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

Yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

EMR

Notes

Allowance is cumulative and is restricted to the purchase of allowed OTC items (besides the OTC Benefit included in section 13b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Package ID	Package Name	Type of Package	Status

Yes

Maximum amount

$150.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to the purchase of food and groceries and grocery delivery charges combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$150.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Package ID	Package Name	Type of Package	Status

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to access to cultural, social and entertainment events combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$150.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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Package ID	Package Name	Type of Package	Status

No

Notes

Allowance is 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, thorough housecleaning performed by a professional and cleaning products combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

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Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

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No

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Notes

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

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

EMR

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

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Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

EMR

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

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Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

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No

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

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Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Is there a deductible?

No

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

Yes

Authorization required for this benefit?

Yes

Notes

0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non-preferred brands and manufacturers.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

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 and for Cardiovascular Devices.

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

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

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

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Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

true

Authorization required for this benefit?

No

Referral required for this benefit?

No

EMR

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

EMR

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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Authorization required for this benefit?

No

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

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Part D to Part B

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

EMR

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Is there a medicare covered deductible?

No

EMR

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Acupuncture - Number of Treatments (13a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

12

Periodicity

Every Year

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$150.00

Periodicity

Every Month

Description

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.

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EMR

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Notes

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Covid-19 tests, Dermatologicals, First Aid supplies, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Mouth care, Multivitamins, Naloxone product, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Optic Agents, Supportive items for comfort, Topical Sunscreen, Urinary Analgesics, Vaginal Products, Vitamins, Weight loss items, Adult Diapers/Pads and Blood Pressure Monitor. Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Setting

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Individual Sessions

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Web/Phone-based technologies?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Web/Phone-based technologies?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Number of visits

Individual Sessions

Session duration (in minutes):

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Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

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No

Referral required for this benefit?

No

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

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1750.00

Periodicity

Every Year

Is there a deductible?

No

Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

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Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Comprehensive oral evaluation – (Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year. Diagnostic services are not deducted from the annual maximum benefit limit.

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Restorative Services (16b3) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond

Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

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Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Root Gingival flap procedure: One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Complete or partial maxillary and mandibular dentures including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months. /

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

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No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

Eyewear Exam (17a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

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Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$400.00

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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No

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a deductible?

No

Is there a maximum plan benefit coverage?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

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No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1000.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

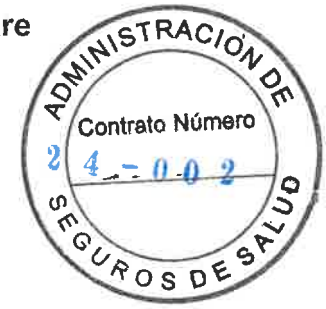
Is there a deductible?

No

Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

Hearing Aids (all types) (18b1) - Non-Medicare



Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

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Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

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Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$19.00

Daily Copayment 1-month

$0.63

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$38.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.52

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$19.00

Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 2 - Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$20.00

Daily Copayment 1-month

$0.67

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$40.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

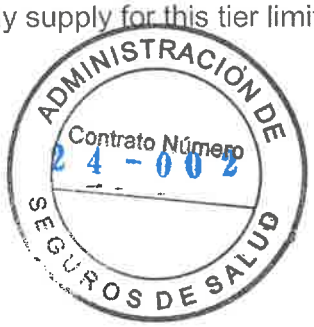
$34.00

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

Yes

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

No



Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.55

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$20.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

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Copayment 3-month supply

$94.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$42.00

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Daily Copayment 1-month

$1.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

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90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

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Daily Copayment 1-month

$3.17

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$100.00

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Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

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Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

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3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

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Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$9.00

Daily Copayment 1-month

$0.30

3-Month Supply

Select days for 3-month supply

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90

Copayment 3-month supply

$18.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.26

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$9.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Insulin

Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

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Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply
$9.00

Copayment 3-month supply
$18.00

Preferred Retail

Copayment 1-month supply
$8.00

Copayment 3-month supply
$16.00

Standard Mail-Order

Copayment 3-month supply
$16.00

Long-Term Care

Copayment 1-month supply
$8.00

Out-of-Network

Copayment 1-month supply
$9.00

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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

028 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Blindao (HMO D-SNP)	Puerto Rico

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?

Yes

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Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No

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Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

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Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

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Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

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Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)	Required	Mandatory
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)		
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

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Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear Eye Exam(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes

Services	In-Network
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes

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Services	In-Network
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	

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Services	In-Network
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)

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Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)
Other Health Care Professional(7g)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Chiropractic Services(7b)
Routine Chiropractic Care(7b1)
Physician Specialist Services(7d)
Podiatry Services(7f)
Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Additional Telehealth Benefits(7j)

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

Cost Share Groups

EMR

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
Combined Supplemental	Other	No	N/A	12 - Every Year	Completed

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status

Benefits 1

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

Acupuncture - Number of Treatments(13a)

Alternative Therapies(14c17)

Name of Other Delivery:

Provider Network

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

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VBID

Does this plan offer VBID hospice benefits?

Yes

Does this plan offer Part C benefits under the VBID model?

No

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

Yes

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment
Care Management Program
In-home Assessments

EMR

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

Enter the Expected Number of Beneficiaries to be Engaged Annually

3025

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

Other, Describe

Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments

EMR

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

EMR

Select the type(s) of hospice supplemental benefits offered

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

Package ID	Package Name	Type of Package	Status
1	Package 1	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Chronic Obstructive Pulmonary Disease (COPD),
Congestive Heart Failure (CHF),
Other 1,
Other 2,
Other 3,
Other 4,
Other 5

Other 1 Description

Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

Other 2 Description

Acute Stroke

Other 3 Description

Abdominal, Hip, knee or open heart surgery

EMR

Package ID	Package Name	Type of Package	Status

Other 4 Description

COPD patients with supplemental oxygen dependency

Other 5 Description

Bedridden patients

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

Notes

Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Patients with Active Chemo by Infusion or systemic radiotherapy - Patients discharged from open heart surgery, abdominal surgery, hip surgery or knee surgery with transition of care to patient's home - COPD patients with supplemental oxygen dependency - Bedridden patients

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

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Package ID	Package Name	Type of Package	Status

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 120 hours of care in a calendar year, (4) hours per day for a maximum of (30) days in the calendar year.

2	Package 2	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Other 1

Other 1 Description

Bedridden patients with specific essential services requirements

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

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

Package Selected Benefit Details

Package ID	Package Name	Type of Package	Status

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

After meeting with the care manager once every quarter, the benefit will be available in blocks of 60 hours per quarter (not cumulative) for a maximum of 240 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, non-invasive / nonclinical 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.

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EMR

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

EMR

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

EMR

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EMR

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

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Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

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EMR

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

EMR

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

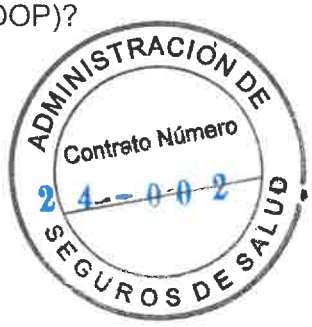
Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No



Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

EMR

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

EMR

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Is there a deductible?

No

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

Yes

Authorization required for this benefit?

Yes

Notes

0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non-preferred brands and manufacturers.

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

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.

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Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance

0% 5%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

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

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

EMR

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

true

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EMR

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

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Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

EMR

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Is there a medicare covered deductible?

No

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

EMR

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van

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Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Acupuncture - Number of Treatments (13a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

12

Periodicity

Every Year

Is there a coinsurance?

No

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EMR

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

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Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Setting

Individual Sessions

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Web/Phone-based technologies?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Web/Phone-based technologies?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Session duration (in minutes):

1

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of

family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$2750.00

Periodicity

Every Year

Is there a deductible?

No

Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

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EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Comprehensive oral evaluation – (Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year. Diagnostic services are not deducted from the annual maximum benefit limit.

Restorative Services (16b3) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-

up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond

Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

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Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Root Gingival flap procedure: One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

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Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EMR

Notes

Complete or partial maxillary and mandibular denture including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months.

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear Eye Exam (17a2) - Non-Medicare

Is this benefit unlimited?

No

EMR

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$500.00

Is there a deductible?

No

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Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

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Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

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EMR

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1500.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Authorization required for this benefit?

No

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

EMR

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

EMR

Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$19.00

Daily Copayment 1-month

$0.63

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$38.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

EMR

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.52

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$19.00

Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 2 - Generic

EMR

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$20.00

Daily Copayment 1-month

$0.67

3-Month Supply

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EMR

Select days for 3-month supply

90

Copayment 3-month supply

$40.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Long Term Care

Select days for long-term care supply

31

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
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EMR

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.55

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$20.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$94.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

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24-002

EMR

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

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EMR

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.17

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

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EMR

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$100.00

Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

EMR

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

EMR

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$9.00

Daily Copayment 1-month

$0.30

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$18.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

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EMR

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.26

Out of Network

Select days for out of network 1-month supply

30

ADMINISTRACIÓN DE SEGUROS DE SALUD
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EMR

Copayment 1-month supply

$9.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Insulin

Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

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EMR

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply

$9.00

Copayment 3-month supply

$18.00

Preferred Retail

Copayment 1-month supply

$8.00

Copayment 3-month supply

$16.00

Standard Mail-Order

Copayment 3-month supply

$16.00

Long-Term Care

Copayment 1-month supply

$8.00

Out-of-Network

Copayment 1-month supply

$9.00

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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

EMR

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

026 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Advance (HMO D-SNP)	Puerto Rico

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?

Yes

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Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No

EMR

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

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Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

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EMR

Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

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EMR

Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

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EMR

Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)	Required	Mandatory
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)		
Over-the-Counter (OTC) Items(13b)		
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

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EMR

Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)		
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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EMR

Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear Exam(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

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Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

Does this plan have tiered cost sharing for Medicare covered services?

Yes

Select the Medicare-covered benefits that have tiered cost sharing:

Podiatry Services(7f)

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

No

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

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Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

EMR

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes

Services	In-Network
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes

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Services	In-Network
Lab Services(8a2)	Yes
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes

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Services	In-Network
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Other Health Care Professional(7g)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)

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Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)
Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Chiropractic Services(7b)
Routine Chiropractic Care(7b1)
Physician Specialist Services(7d)
Podiatry Services(7f)
Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Additional Telehealth Benefits(7j)

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

EMR

Cost Share Groups

Combined Benefits Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

VBID

Does this plan offer VBID hospice benefits?

Yes

Does this plan offer Part C benefits under the VBID model?

Yes

Select benefits:

Value-based design flexibilities by condition or socioeconomic state,

I attest that: TRUE

1) the benefits entered comply with CMS required for benefits offered in the VBID model
2) the benefits entered are consistent with the benefit proposals and the actuarial or financial information provided to CMS when applying to participate in the VBID Model, unless otherwise approved by CMS in writing, and
3) the benefit package, formulary or other features of this plan are not structured to discriminate against any Medicare beneficiary.

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

Yes

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment
Care Management Program
In-home Assessments

EMR

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

Enter the Expected Number of Beneficiaries to be Engaged Annually

2142

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

Other, Describe

Health risk assessment, Social work assessment, RN Outreach assessment and Social determinants of health assessments.

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

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EMR

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

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Select the type(s) of hospice supplemental benefits offered

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

EMR

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

Package ID	Package Name	Type of Package	Status
1	Package 1	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Chronic Obstructive Pulmonary Disease (COPD),
Congestive Heart Failure (CHF),
Other 1,
Other 2,
Other 3,
Other 4,
Other 5

Other 1 Description

Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

Other 2 Description

Acute Stroke

Other 3 Description

Abdominal, Hip, knee or open heart surgery

Other 4 Description

COPD patients with supplemental oxygen dependency

Other 5 Description

Bedridden patients

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

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Package ID	Package Name	Type of Package	Status

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

Notes

Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Patients with Active Chemo by Infusion or systemic radiotherapy - Patients discharged from open heart surgery, abdominal surgery, hip surgery or knee surgery with transition of care to patient's home - COPD patients with supplemental oxygen dependency - Bedridden patients

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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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

Package ID	Package Name	Type of Package	Status

aide on activities of daily living due to health issues not otherwise covered under any other Medicare benefit. Covers up to 120 hours of care in a calendar year, (4) hours per day for a maximum of (30) days in the calendar year.

2	Package 2	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Other 1

Other 1 Description

Bedridden patients with specific essential services requirements

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

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

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

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Package ID	Package Name	Type of Package	Status

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

After meeting with the care manager once every quarter, the benefit will be available in blocks of 60 hours per quarter (not cumulative) for a maximum of 240 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, non-invasive / nonclinical 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.

3	Package 3	VBID	Completed

Select Target Methodology (Required)

Socioeconomic Status,

Expected Number of Enrollees to be Targeted

3105

Expected Number of Enrollees to be engaged and receive Model benefits

3105

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
General Supports for Living (13i10),
Food and Produce (13i1),
Social Needs Benefit (13i6)

Are any benefits exempt from the plan-level deductible?

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Package ID	Package Name	Type of Package	Status

No

Is there a package level maximum coverage amount?

Yes

Specify the maximum benefit amount

$165.00

Periodicity

Every Month

Indicate mode of delivery for maximum coverage amount

Debit Card

Select all the Non-Medicare-covered benefits that apply to the package level maximum coverage

Transportation Services - Any Health-related Location (10b2),
Over-the-Counter (OTC) Items (13b),
Food and Produce (13i1),
Social Needs Benefit (13i6),
General Supports for Living (13i10)

Notes

Members will be sent a card with an allowance for the purchase of food, groceries cleaning products, allowed OTC items, grocery delivery charges, thorough house cleaning performed by a contracted professional, purchase of gasoline through contracted merchants, access to cultural, social and entertainment events, copays and coinsurances, additional transportation (besides the transportation benefit in section 10b) and for utilities restricted to: propane gas, water, electricity, internet, telephone, cable tv / satellite through contracted merchants. Benefit is cumulative and funds will be deposited once every month of the year while the member remains active in the plan.

Package Selected Benefit Details

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

Yes

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

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EMR

Package ID	Package Name	Type of Package	Status

Allowance is cumulative and is restricted additional transportation to medical destinations, through contracted vendors (besides the transportation benefit in section 10b).

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$165.00

Periodicity

Every Month

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted additional transportation to medical destinations (medical appointments in any medical facility, preventive services activities, and picking up prescriptions at pharmacies) through contracted vendors (besides the transportation benefit in section 10b) combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$165.00

Periodicity

Every Month

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Package ID	Package Name	Type of Package	Status

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

Yes

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

Notes

Allowed items: Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Covid-19 tests, Dermatologicals, First Aid supplies, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Mouth care, Multivitamins, Naloxone product, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Optic Agents, Supportive items for comfort, Topical Sunscreen, Urinary Analgesics, Vaginal Products, Vitamins, Weight loss items, Adult Diapers/Pads and Blood Pressure Monitor. Up to one (1) blood pressure monitor every 5 years for members with certain conditions. Allowance is cumulative and is restricted to the purchase of allowed OTC items combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Food and Produce (13i1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$165.00

Periodicity

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EMR

Package ID	Package Name	Type of Package	Status

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to the purchase of food and groceries and grocery delivery charges combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: -Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

Social Needs Benefit (13i6) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$165.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

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EMR

Package ID	Package Name	Type of Package	Status

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is cumulative and is restricted to access to cultural, social and entertainment events combined with all other VBID Flexible (by Socioeconomic Status) benefits. Benefit will not include: - Beer, wine, liquor, cigarettes, or tobacco - Pet foods, paper products, other household supplies, or cosmetics

General Supports for Living (13i10) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum amount

$165.00

Periodicity

Every Month

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Allowance is 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, thorough housecleaning performed by a

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EMR

Package ID	Package Name	Type of Package	Status

professional and cleaning products combined with all other VBID Flexible (by Socioeconomic Status) benefits.

Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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EMR

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

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EMR

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

EMR

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

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Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

Yes

Copayment amount

$2.00

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

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Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

EMR

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

Yes with a min & max

Minimum copayment	Maximum copayment
$0.00	$2.00

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

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Notes

$0 copay for services rendered in SALUS facility. $2 copay for Medicare covered services.

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

EMR

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

EMR

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	10%

Is there a copayment?

No

Is there a deductible?

No

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

Yes

Authorization required for this benefit?

Yes

Notes

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

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance
0%

Maximum coinsurance
10%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and non-surgically implanted prosthetic device and Cardiovascular Devices.

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance
0%

Maximum coinsurance
10%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

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

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MCOOP)?

No

Is there a deductible?

No

EMR

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

true

Authorization required for this benefit?

No

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

EMR

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

EMR

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

EMR

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

EMR

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Notes

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Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Setting

Individual Sessions

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

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No

Referral required for this benefit?

No

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Number of visits

Individual Sessions

Session duration (in minutes):

20

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$2750.00

Periodicity

Every Year

Is there a deductible?

No

Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Comprehensive oral evaluation – (Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6 months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or

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complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year. Diagnostic services are not deducted from the annual maximum benefit limit.

Restorative Services (16b3) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond.

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Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

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Yes

Referral required for this benefit?

No

Notes

Root Gingival flap procedure – One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment.

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth.

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Complete or partial maxillary and mandibular denture including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months.

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

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Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear Exam (17a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$500.00

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a deductible?

No

Is there a maximum plan benefit coverage?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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No

Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1500.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

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Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

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Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$19.00

Daily Copayment 1-month

$0.63

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$38.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

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Select days for 3-month supply

90

Copayment 3-month supply

$32.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.52

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$19.00

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Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 2 - Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$20.00

Daily Copayment 1-month

$0.67

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$40.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.55

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$20.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

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Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$94.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

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Select days for long-term care supply

31

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.17

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$100.00

Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

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Out of Network

Select days for out of network 1-month supply

30

Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

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Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$9.00

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Daily Copayment 1-month

$0.30

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$18.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.26

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$9.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

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Rx Insulin

Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply
$9.00

Copayment 3-month supply
$18.00

Preferred Retail

Copayment 1-month supply
$8.00

Copayment 3-month supply
$16.00

Standard Mail-Order

Copayment 3-month supply
$16.00

Long-Term Care

Copayment 1-month supply
$8.00

Out-of-Network

Copayment 1-month supply
$9.00

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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

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PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM REPORT

Contract Year: 2024

Requested By: ROBERTO GONZALEZ CORCHADO

H5774

024 TRIPLE S ADVANTAGE, INC. - Data Report

Plan Characteristics

General Information

Organization Legal Name	Organization Marketing Name	Organization Type
TRIPLE S ADVANTAGE, INC.	Triple S Advantage	Local CCP

Plan Name	Plan Geographic Name
Platino Plus (HMO D-SNP)	Puerto Rico

Plan Details

Plan Type	Is this a network plan?	Is this an Employer-Only Plan?
HMO	Not Available	No

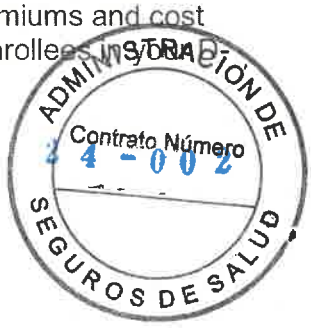
Does this plan offer Prescription drugs (Rx)?	Does this plan offer Point of Service (POS)?	Does this plan offer Out-of-Network Services (OON)?
Yes	No	No

Does this plan offer Value Based Insurance Design (VBID)?
Yes

Special Needs Plan

Is this a SNP?	SNP Type	SNP Institutional Type
Yes	Dual-Eligible	Not Available

Does this D-SNP offer Medicare zero-dollar cost-sharing (not applicable to Part D)?	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?
Not Available	No



EMR

Plan Attributes

Select Enrollee type:

Part A & Part B

Does this Plan have a CMS-approved Continuation Area?

No

Does this plan intend to participate in the Platino program?

Yes

Standard Bid

Does this plan offer a standard bid for In-Network service categories?	Does this plan offer a standard bid for plan-level deductible and maximum enrollee out-of-pocket cost (MOOP)?	Does this plan offer a standard bid for Visitor Travel Program V/T?
No	No	No

Benefit Offerings

Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Required
Inpatient Hospital Psychiatric(1b)	Required
Skilled Nursing Facility (SNF)(2)	Required
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Required
Intensive Cardiac Rehabilitation Services(3-2)	Required
Pulmonary Rehabilitation Services(3-3)	Required
SET for PAD Services(3-4)	Required
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Required
Urgently Needed Services(4b)	Required
Partial Hospitalization(5)	Required
Home Health Services(6)	Required
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Required
Chiropractic Services(7b)	Required
Occupational Therapy Services(7c)	Required

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Services	In Network (INN)
Physician Specialist Services(7d)	Required
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Required
Group Sessions for Mental Health Specialty Services(7e2)	Required
Podiatry Services(7f)	Required
Other Health Care Professional(7g)	Required
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Required
Group Sessions for Psychiatric Services(7h2)	Required
Physical Therapy and Speech-Language Pathology Services(7i)	Required
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Required
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Required
Lab Services(8a2)	Required
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Required
Therapeutic Radiological Services(8b2)	Required
Outpatient X-Ray Services(8b3)	Required
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Required
Observation Services(9a2)	Required
Ambulatory Surgical Center (ASC) Services(9b)	Required
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Required
Group Sessions for Outpatient Substance Abuse(9c2)	Required
Outpatient Blood Services(9d)	Required

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Services	In Network (INN)
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Required
Air Ambulance Services(10a2)	Required
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Required
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Required
Medical Supplies(11b2)	Required
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Required
Diabetic Therapeutic Shoes/Inserts(11c2)	Required
Dialysis Services(12)	Required
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Required
Kidney Disease Education Services(14d)	Required
Other Medicare-covered Preventive Services(14e)	
Glaucoma Screening(14e1)	Required
Diabetes Self-Management Training(14e2)	Required
Barium Enemas(14e3)	Required
Digital Rectal Exams(14e4)	Required
EKG following Welcome Visit(14e5)	Required
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Required
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Required
Other Medicare Part B Drugs(15-3)	Required
Dental(16)	
Comprehensive Dental(16b)	Required
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Required
Eyewear(17b)	Required

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EMR

Services	In Network (INN)
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Required

Non-Medicare Services

Showing all the service categories that are being offered under the plan

Services	In Network (INN)	Optional/Mandatory / Both
Inpatient Hospital Services(1)		
Inpatient Hospital-Acute(1a)		
Additional Days for Inpatient Hospital-Acute(1a1)	Required	Mandatory
Non-Medicare-covered Stay for Inpatient Hospital-Acute(1a2)		
Upgrades for Inpatient Hospital-Acute(1a3)		
Inpatient Hospital Psychiatric(1b)		
Additional Days for Inpatient Hospital Psychiatric(1b1)		
Non-Medicare-covered Stay for Inpatient Hospital Psychiatric(1b2)		
Skilled Nursing Facility (SNF)(2)		
Additional Days beyond Medicare-covered for Skilled Nursing Facility (SNF)(2-1)		
Cardiac and Pulmonary Rehabilitation Services(3)		
Additional Cardiac Rehabilitation Services(3-1)		
Additional Intensive Cardiac Rehabilitation Services(3-2)		
Additional Pulmonary Rehabilitation Services(3-3)		
Additional SET for PAD Services(3-4)		
Emergency/Urgently Needed Services(4)		
Worldwide Emergency/Urgent Coverage(4c)		
Worldwide Emergency Coverage(4c1)	Required	Mandatory
Worldwide Urgent Coverage(4c2)	Required	Mandatory
Worldwide Emergency Transportation(4c3)		
Health Care Professional Services(7)		

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Services	In Network (INN)	Optional/Mandatory / Both
Chiropractic Services(7b)		
Routine Chiropractic Care(7b1)	Required	Mandatory
Other Chiropractic Services(7b2)		
Podiatry Services: Routine Foot Care(7f)	Required	Mandatory
Outpatient Services(9)		
Outpatient Blood Services(9d)		
Three(3) pint Deductible Waived(9d)	Required	Mandatory
Ambulance/Transportation Services(10)		
Transportation Services(10b)		
Transportation Services - Plan Approved Health-related Location(10b1)		
Transportation Services - Any Health-related Location(10b2)	Required	Mandatory
Other Supplemental Services(13)		
Acupuncture - Number of Treatments(13a)	Required	Mandatory
Over-the-Counter (OTC) Items(13b)	Required	Mandatory
Meal Benefit(13c)		
Other 1(13d)		
Other 2(13e)		
Other 3(13f)		
Dual Eligible SNPs with Highly Integrated Services(13g)		
Preventive and Other Defined Supplemental Services(14)		
Annual Physical Exam(14b)		
Other Defined Supplemental Benefits(14c)		
Health Education(14c1)	Required	Mandatory
Nutritional/Dietary Benefit(14c2)	Required	Mandatory
Additional Sessions of Smoking and Tobacco Cessation Counseling(14c3)		
Fitness Benefit(14c4)		
Enhanced Disease Management(14c5)		
Telemonitoring Services(14c6)		

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Services	In Network (INN)	Optional/Mandatory / Both
Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)(14c7)	Required	Mandatory
Home and Bathroom Safety Devices and Modifications(14c8)		
Counseling Services(14c9)	Required	Mandatory
In-Home Safety Assessment(14c10)		
Personal Emergency Response System (PERS)(14c11)		
Medical Nutrition Therapy (MNT)(14c12)		
Post discharge In-Home Medication Reconciliation(14c13)		
Re-admission Prevention(14c14)		
Wigs for Hair Loss Related to Chemotherapy(14c15)		
Weight Management Programs(14c16)		
Alternative Therapies(14c17)	Required	Mandatory
Therapeutic Massage(14c18)		
Adult Day Health Services(14c19)		
Home-Based Palliative Care(14c20)		
In-Home Support Services(14c21)		
Support for Caregivers of Enrollees(14c22)		
Home infusion bundled services(15)	Required	Mandatory
Dental(16)		
Preventive Dental(16a)		
Oral Exams(16a1)		
Prophylaxis (Cleaning)(16a2)		
Fluoride Treatment(16a3)		
Dental X-Rays(16a4)		
Comprehensive Dental(16b)		
Non-routine Services(16b1)	Required	Mandatory
Diagnostic Services(16b2)	Required	Mandatory
Restorative Services(16b3)	Required	Mandatory
Endodontics(16b4)	Required	Mandatory

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Services	In Network (INN)	Optional/Mandatory / Both
Periodontics(16b5)	Required	Mandatory
Extractions(16b6)	Required	Mandatory
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)	Required	Mandatory
Eye Exams/Eyewear(17)		
Eye Exams(17a)		
Routine Eye Exams(17a1)	Required	Mandatory
Eyewear Exam(17a2)	Required	Mandatory
Eyewear(17b)		
Contact Lenses(17b1)	Required	Mandatory
Eyeglasses (lenses and frames)(17b2)	Required	Mandatory
Eyeglass lenses(17b3)	Required	Mandatory
Eyeglass frames(17b4)	Required	Mandatory
Upgrades(17b5)	Required	Mandatory
Hearing Exams/Hearing Aids(18)		
Hearing Exams(18a)		
Routine Hearing Exams(18a1)	Required	Mandatory
Fitting/Evaluation for Hearing Aid(18a2)	Required	Mandatory
Hearing Aids(18b)		
Hearing Aids (all types)(18b1)	Required	Mandatory
Hearing Aids - Inner Ear(18b2)		
Hearing Aids - Outer Ear(18b3)		
Hearing Aids - Over the Ear(18b4)		

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número ? - 02

Plan Level Cost Sharing

Plan Level Cost Sharing

Tiered Cost Sharing

Does this plan have tiered cost sharing for Medicare covered services?

No

Does this plan have tiered cost sharing for Non-Medicare covered services?

No

Reductions in Cost Sharing

Does your plan offer Reductions in Cost Sharing?

No

Combined Supplemental Benefits

Do you offer Combined Supplemental Benefits?

Yes

Annual Plan Deductible

Does this plan have an In-Network plan deductible?

No

Max Enrollee Cost Limit

Does this plan have an In-Network MOOP?

Yes

What type of In-Network MOOP does your plan offer?

Lower

In Network MOOP Amount

$3650.00

Select the Service Categories that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:

In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?

Yes

Medicare Services

Select the Medicare service categories that are subject to each MOOP type:

Services	In-Network
Inpatient Hospital Services(1)	
Inpatient Hospital-Acute(1a)	Yes
Inpatient Hospital Psychiatric(1b)	Yes
Skilled Nursing Facility (SNF)(2)	Yes

Services	In-Network
Cardiac and Pulmonary Rehabilitation Services(3)	
Cardiac Rehabilitation Services(3-1)	Yes
Intensive Cardiac Rehabilitation Services(3-2)	Yes
Pulmonary Rehabilitation Services(3-3)	Yes
SET for PAD Services(3-4)	Yes
Emergency/Urgently Needed Services(4)	
Emergency Services(4a)	Yes
Urgently Needed Services(4b)	Yes
Partial Hospitalization(5)	Yes
Home Health Services(6)	Yes
Health Care Professional Services(7)	
Primary Care Physician Services(7a)	Yes
Chiropractic Services(7b)	Yes
Occupational Therapy Services(7c)	Yes
Physician Specialist Services(7d)	Yes
Mental Health Specialty Services(7e)	
Individual Sessions for Mental Health Specialty Services(7e1)	Yes
Group Sessions for Mental Health Specialty Services(7e2)	Yes
Podiatry Services(7f)	Yes
Other Health Care Professional(7g)	Yes
Psychiatric Services(7h)	
Individual Sessions for Psychiatric Services(7h1)	Yes
Group Sessions for Psychiatric Services(7h2)	Yes
Physical Therapy and Speech-Language Pathology Services(7i)	Yes
Additional Telehealth Benefits(7j)	Yes
Opioid Treatment Program Services(7k)	Yes
Outpatient Procedures, Tests, Labs and Radiology Services(8)	
Diagnostic Procedures/Tests/Lab Services(8a)	
Diagnostic Procedures/Tests(8a1)	Yes
Lab Services(8a2)	Yes

EMR

Services	In-Network
Outpatient Diagnostic/Therapeutic Radiological Services(8b)	
Diagnostic Radiological Services(8b1)	Yes
Therapeutic Radiological Services(8b2)	Yes
Outpatient X-Ray Services(8b3)	Yes
Outpatient Services(9)	
Outpatient Hospital Services(9a)	
Outpatient Hospital Services(9a1)	Yes
Observation Services(9a2)	Yes
Ambulatory Surgical Center (ASC) Services(9b)	Yes
Outpatient Substance Abuse(9c)	
Individual Sessions for Outpatient Substance Abuse(9c1)	Yes
Group Sessions for Outpatient Substance Abuse(9c2)	Yes
Outpatient Blood Services(9d)	Yes
Ambulance/Transportation Services(10)	
Ambulance Services(10a)	
Ground Ambulance Services(10a1)	Yes
Air Ambulance Services(10a2)	Yes
DME, Prosthetics and Medical and Diabetic Supplies(11)	
Durable Medical Equipment (DME)(11a)	Yes
Prosthetics/Medical Supplies(11b)	
Prosthetic Devices(11b1)	Yes
Medical Supplies(11b2)	Yes
Diabetic Supplies and Services(11c)	
Diabetic Supplies(11c1)	Yes
Diabetic Therapeutic Shoes/Inserts(11c2)	Yes
Dialysis Services(12)	Yes
Preventive and Other Defined Supplemental Services(14)	
Medicare-covered Zero Dollar Preventive Services(14a)	Yes
Kidney Disease Education Services(14d)	Yes
Other Medicare-covered Preventive Services(14e)	

EMR

Services	In-Network
Glaucoma Screening(14e1)	Yes
Diabetes Self-Management Training(14e2)	Yes
Barium Enemas(14e3)	Yes
Digital Rectal Exams(14e4)	Yes
EKG following Welcome Visit(14e5)	Yes
Medicare Part B Rx Drugs(15)	
Medicare Part B Insulin Drugs(15-1)	Yes
Medicare Part B Chemotherapy/Radiation Drugs(15-2)	Yes
Other Medicare Part B Drugs(15-3)	Yes
Dental(16)	
Comprehensive Dental(16b)	Yes
Eye Exams/Eyewear(17)	
Eye Exams(17a)	Yes
Eyewear(17b)	Yes
Hearing Exams/Hearing Aids(18)	
Hearing Exams(18a)	Yes

Prior Authorization & Referral

Prior Authorization

Is prior authorization required for any In-Network service categories?

Yes

Select the In-Network service categories that require prior authorization:

Skilled Nursing Facility (SNF)(2)
Cardiac Rehabilitation Services(3-1)
Intensive Cardiac Rehabilitation Services(3-2)
Pulmonary Rehabilitation Services(3-3)
SET for PAD Services(3-4)
Partial Hospitalization(5)
Home Health Services(6)
Occupational Therapy Services(7c)
Physician Specialist Services(7d)
Physical Therapy and Speech-Language Pathology Services(7i)
Diagnostic Procedures/Tests(8a1)
Lab Services(8a2)
Diagnostic Radiological Services(8b1)
Therapeutic Radiological Services(8b2)
Outpatient X-Ray Services(8b3)
Outpatient Hospital Services(9a1)

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Observation Services(9a2)
Ambulatory Surgical Center (ASC) Services(9b)
Ground Ambulance Services(10a1)
Air Ambulance Services(10a2)
Durable Medical Equipment (DME)(11a)
Prosthetic Devices(11b1)
Medical Supplies(11b2)
Medicare Part B Insulin Drugs(15-1)
Medicare Part B Chemotherapy/Radiation Drugs(15-2)
Other Medicare Part B Drugs(15-3)
Comprehensive Dental(16b)
Non-routine Services(16b1)
Diagnostic Services(16b2)
Restorative Services(16b3)
Endodontics(16b4)
Periodontics(16b5)
Extractions(16b6)
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services(16b7)
Other Health Care Professional(7g)

Referral

Is referral required for any In-Network service categories?

Yes

Select the In-Network service categories that requires a referral:

Chiropractic Services(7b)
Routine Chiropractic Care(7b1)
Physician Specialist Services(7d)
Podiatry Services(7f)
Podiatry Services: Routine Foot Care(7f)
Other Health Care Professional(7g)
Additional Telehealth Benefits(7j)

Visitor Travel

Does this plan offer the US Visitor/Travel Program (V/T)?

No

EMR

Cost Share Groups

Combined Benefits Groups

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status
Combined Supplemental	Other	No	N/A	12 - Every Year	Completed

Group Name	Mode of delivery	Maximum Plan Benefit Coverage amount	Periodicity	Shared Visit/Trips Limits	Status

Benefits 1

Non-Medicare covered benefits that are included in your Combined Supplemental Benefit Group:

Acupuncture - Number of Treatments(13a)

Alternative Therapies(14c17)

Name of Other Delivery:

network provider

Reduction in Cost Sharing Groups

No Data Saved for Selected Section, Incomplete or Not Started.

Optional Supplemental Packages

No Data Saved for Selected Section, Incomplete or Not Started.

VBID

Does this plan offer VBID hospice benefits?

Yes

Does this plan offer Part C benefits under the VBID model?

No

Does this plan include MA Uniformity Flexibility with reductions in cost or additional benefits?

Yes

Does this plan offer Special Supplemental Benefits for Chronically Ill?

No

EMR

VBID - WHP

Describe how this plan offers Wellness and Health Care Planning (WHP) services, including Advance Care Planning:

Annual Wellness Visit
Medicare Health Risk Assessment
Care Management Program
In-home Assessments

EMR

Select the WHP mode of engagement:

Telephonic
In Person
Web-based

Does your organization offer Part C Rewards or Incentives for beneficiaries under WHP services?

No

Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?

No

Program Connectedness. Select how your advance care plans and/ or advance directives are connected from your program to access points of care:

Electronic Health Records or Electronic Medical Records
Provider/ Patient portals
Health Information Exchanges
Data Warehouses

Enter the Expected Number of Beneficiaries to be Engaged Annually

5741

VBID - HEP

Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply)

Internal data sources
External data sources
Patient feedback
Caregiver feedback
Provider feedback
Patient/caregiver/community health needs assessment

Identify actions within your VBID HEP. (Select all that apply)

Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population
Identify priority population(s) and associated disparities that will be addressed
Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs
Monitor own health equity efforts
Engage enrollees, caregivers, providers and/or communities in health equity efforts

Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply)

Other, Describe

Other, Describe

EMR

Health Risk Assessment, Social Work Assessment, RN Outreach Assessment and Social Determinants of Health Assessment

VBID - Hospice

In-Network Hospice Benefit

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Out-of-Network Hospice Benefits

Does this plan have enrollee coinsurance?

No

Does this plan have enrollee copayments?

No

Cost sharing for a respite care day:

Does this plan have enrollee coinsurance?

No

Hospice Supplemental Benefits

Does this plan offer Hospice Supplemental Benefits?

Yes

Is there a maximum plan benefit amount?

No

Are hospice supplemental benefits contingent upon receiving services from an In-Network provider?

Yes

Does this plan include coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization?

No

Select the type(s) of hospice supplemental benefits offered

EMR

Does this plan include 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?

No

Does this plan include reduced cost sharing for unrelated medical care services received during hospice election?

No

Does this plan offer other mandatory supplemental benefits?

Yes

Other, Describe

In-Home Support

Notes (section)

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 in-network and out-of-network hospice benefits.

VBID - RIR

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - RIC

No Data Saved for Selected Section, Incomplete or Not Started.

VBID - ABP

Package ID	Package Name	Type of Package	Status
1	Package 1	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Chronic Obstructive Pulmonary Disease (COPD),
Congestive Heart Failure (CHF),
Other 1,
Other 2,
Other 3,
Other 4,
Other 5,
Diabetes

Other 1 Description

Oncology Patients with Active Chemo by Infusion or systemic radiotherapy

EMR

Other 2 Description

Acute Stroke

Other 3 Description

Package ID	Package Name	Type of Package	Status

Abdominal, Hip, knee or open heart surg

Other 4 Description

COPD patients with supplemental oxygen dependency

Other 5 Description

Bedridden patients

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

Notes

Benefit eligibility will be based on medical recommendation, and the following conditions: - Post Inpatient stay for Heart Failure (CHF), any class with transition of care to patient's home - Post Inpatient stay for Chronic Obstructive Pulmonary Disease (COPD), with transition of care to patient's home - Post Inpatient stay for Acute Stroke with transition of care to patient's home - Oncology Patients with Active Chemo by Infusion or systemic radiotherapy - Patients discharged from open heart surgery, abdominal surgery, hip surgery or knee surgery with transition of care to patient's home - COPD patients with supplemental oxygen dependency - Bedridden patients

Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

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Package ID	Package Name	Type of Package	Status

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 120 hours of care in a calendar year, (4) hours per day for a maximum of (30) days in the calendar year.

2	Package 2	MA Uniformity Flexibility	Completed

Disease state - Please choose one or more

Other 1

Other 1 Description

Bedridden patients with specific essential services requirements

Prerequisite for any additional benefits for this package?

No

Select all the Non-Medicare-covered additional benefits offered in this package

In-Home Support Services (14c21)

Are any benefits exempt from the plan-level deductible?

No

Is there a package level maximum coverage amount?

No

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

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Package Selected Benefit Details

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

EMR

Package ID	Package Name	Type of Package	Status

No

In-Home Support Services (14c21) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

After meeting with the care manager once every quarter, the benefit will be available in blocks of 60 hours per quarter (not cumulative) for a maximum of 240 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, non-invasive / 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.

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Benefit Details

Inpatient Hospital-Acute (1a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

EMR

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Inpatient Hospital Psychiatric (1b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

What is your Inpatient Hospital- Acute benefit period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

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EMR

No

Referral required for this benefit?

No

Skilled Nursing Facility (SNF) (2) - Medicare

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Does this plan's Medicare-covered benefit cost sharing vary by Skilled Nursing Facility in which an enrollee obtains care?

No

Is there a coinsurance?

No

Is there a copayment?

No

What is your SNF period?

Periodicity

Per Admission or Per Stay

Do you charge cost sharing on the day of discharge?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Cardiac and Pulmonary Rehabilitation Services (3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

EMR

Cardiac Rehabilitation Services (3-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Intensive Cardiac Rehabilitation Services (3-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Pulmonary Rehabilitation Services (3-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

SET for PAD Services (3-4) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Emergency Services (4a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

Urgently Needed Services (4b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Notes

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

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Partial Hospitalization (5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

EMR

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Home Health Services (6) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Primary Care Physician Services (7a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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Chiropractic Services (7b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a medicare covered coinsurance?

No

Is there a medicare covered copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Occupational Therapy Services (7c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Physician Specialist Services (7d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

Mental Health Specialty Services (7e) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Mental Health Specialty Services (7e1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Mental Health Specialty Services (7e2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Podiatry Services (7f) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a medicare covered deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Other Health Care Professional (7g) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

Yes

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Psychiatric Services (7h) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Psychiatric Services (7h1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Group Sessions for Psychiatric Services (7h2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Physical Therapy and Speech-Language Pathology Services (7i) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

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Yes

Referral required for this benefit?

No

Additional Telehealth Benefits (7j) - Medicare

Medicare-covered benefits that may have Additional Telehealth Benefits available

Primary Care Physician Services(7a)
Physician Specialist Services(7d)
Individual Sessions for Mental Health Specialty Services(7e1)
Individual Sessions for Psychiatric Services(7h1)
Kidney Disease Education Services(14d)
Diabetes Self-Management Training(14e2)

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Opioid Treatment Program Services (7k) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

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EMR

No

Referral required for this benefit?

No

Diagnostic Procedures/Tests/Lab Services (8a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Procedures/Tests (8a1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Lab Services (8a2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Outpatient Diagnostic/Therapeutic Radiological Services (8b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a copayment?

No

Is there a deductible?

No

Diagnostic Radiological Services (8b1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Therapeutic Radiological Services (8b2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient X-Ray Services (8b3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Hospital Services (9a1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Observation Services (9a2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

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Ambulatory Surgical Center (ASC) Services (9b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Outpatient Substance Abuse (9c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Individual Sessions for Outpatient Substance Abuse (9c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Group Sessions for Outpatient Substance Abuse (9c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Outpatient Blood Services (9d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Ambulance Services (10a) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Ground Ambulance Services (10a1) - Medicare

Does this plan have a ground ambulance services maximum enrollee out of pocket cost (MOOP)?

EMR

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Air Ambulance Services (10a2) - Medicare

Does this plan have an air ambulance services maximum enrollee out of pocket(MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for non-emergency Medicare services?

Yes

Durable Medical Equipment (DME) (11a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Is there a deductible?

No

EMR

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

Yes

Authorization required for this benefit?

Yes

Notes

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

Prosthetics/Medical Supplies (11b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Prosthetic Devices (11b1) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

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.

Medical Supplies (11b2) - Medicare

Is there a coinsurance?

Yes with a min & max

Minimum coinsurance	Maximum coinsurance
0%	5%

Is there a copayment?

No

Authorization required for this benefit?

Yes

Notes

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

Diabetic Supplies and Services (11c) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Do you limit Diabetic supplies and services to those from specified manufacturers?

Yes

Diabetic Supplies (11c1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Diabetic Therapeutic Shoes/Inserts (11c2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Dialysis Services (12) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

EMR

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Medicare-covered Zero Dollar Preventive Services (14a) - Medicare

I attest that there is no coinsurance ,copayment or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing

true

Authorization required for this benefit?

No

Referral required for this benefit?

No

Kidney Disease Education Services (14d) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EMR

Glaucoma Screening (14e1) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Referral required for this benefit?

No

Authorization required for this benefit?

No

Diabetes Self-Management Training (14e2) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Barium Enemas (14e3) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Digital Rectal Exams (14e4) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EKG following Welcome Visit (14e5) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

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Referral required for this benefit?

No

Medicare Part B Rx Drugs (15) - Medicare

I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug.

true

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

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

Medicare Part B Insulin Drugs (15-1) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Medicare Part B Chemotherapy/Radiation Drugs (15-2) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

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Other Medicare Part B Drugs (15-3) - Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Comprehensive Dental (16b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Eye Exams (17a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

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No

Referral required for this benefit?

No

Eyewear (17b) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Medicare

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

EMR

Additional Days for Inpatient Hospital-Acute (1a1) - Non-Medicare

Is this benefit unlimited?

Yes

Does this plans Additional Days cost sharing vary by hospital(s) in which an enrollee obtains care?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Worldwide Emergency/Urgent Coverage (4c) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Is the maximum plan benefit coverage amount unlimited?

No

Maximum amount

$75.00

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a deductible?

No

Notes

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

Worldwide Emergency Coverage (4c1) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

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Worldwide Urgent Coverage (4c2) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Chiropractic Services (7b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Routine Chiropractic Care (7b1) - Non-Medicare

Is this benefit unlimited?

No

Visits

5

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Podiatry Services: Routine Foot Care (7f) - Non-Medicare

Is this benefit unlimited?

No

Visits

4

Periodicity

Every Year

Is there a maximum plan benefit coverage amount?

No

EMR

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

Yes

Transportation Services - Any Health-related Location (10b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

30

Periodicity

Every Year

Type of transportation

One-Way

Select Mode of Transportation

Taxi
Van
Other, Describe

Description

Other methods of transportation are available, such as an automobile through a contracted provider.

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a service specific maximum plan benefit coverage amount?

No

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Acupuncture - Number of Treatments (13a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments

12

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

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

Over-the-Counter (OTC) Items (13b) - Non-Medicare

Is there a maximum plan benefit coverage amount?

Yes

Maximum plan benefit coverage amount

$75.00

Periodicity

Every 3 Months

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

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

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

Yes

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

true

Is there a coinsurance?

No

Is there a copayment?

No

Is there a deductible?

No

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

No

EMR

Notes

Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, Covid-19 tests, Dermatologicals, First Aid supplies, Folic Acid, Iron, Laxatives, Minerals & Electrolytes, Mouth care, Multivitamins, Naloxone product, Nasal Agents, Nutritional Supplements such as Fish Oil and Omega 3, Smoking Deterrents, Optic Agents, Supportive items for comfort, Topical Sunscreen, Urinary Analgesics, Vaginal Products, Vitamins, Weight loss items, Adult Diapers/Pads and Blood Pressure Monitor. Up to one (1) blood pressure monitor every 5 years for members with certain conditions.

Other Defined Supplemental Benefits (14c) - Non-Medicare

Is there a deductible?

No

Health Education (14c1) - Non-Medicare

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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.

Nutritional/Dietary Benefit (14c2) - Non-Medicare

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Is this benefit unlimited?

No

Indicate number of visits

12

Setting

Individual Sessions

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) (14c7) - Non-Medicare

Select the type of Remote Access Technologies offered

Nursing Hotline

Is there a maximum plan benefit coverage?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance Nursing Hotline?

No

Is there a copayment Nursing Hotline?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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 (14c9) - Non-Medicare

Is this benefit unlimited?

Yes

Number of visits

Individual Sessions

Session duration (in minutes):

20

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Notes

Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

Alternative Therapies (14c17) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

12

Is there a maximum plan benefit coverage amount?

No

Does this plan have a service specific maximum enrollee out-of-pocket cost (MOOP)?

No

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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

Comprehensive Dental (16b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$4000.00

Periodicity

Every Year

Is there a deductible?

No

Non-routine Services (16b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

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Referral required for this benefit?

No

Notes

Covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)

Diagnostic Services (16b2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Comprehensive oral evaluation – (Initial evaluation) One (1) visit every 3 years/ Periodic oral evaluation – (Follow-up evaluation) One (1) visit every 6 months/ Limited oral evaluation – (Emergency evaluation) One (1) visit every 6 months / Comprehensive periodontal evaluation by a periodontal specialist – One (1) visit every 3 years / one (1) panoramic radiographic image or complete series of intraoral radiographic images including a pair of bitewing X-Rays, every three years, but not both / Pulp vitality test – One (1) every 6 months / Maximum of up to four (4) periapical radiographic images (which can be used in conjunction with the emergency visit) and up to (2) bitewings images per year

Restorative Services (16b3) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Amalgam restorations and resin based composite restoration for anterior and posterior teeth. Replacement considered every 2 years / Prefabricated stainless-steel crown for primary tooth – Allowed once per tooth per life / Protective restoration (sedative)-1 per tooth per life / Core build-up (including any pins, if necessary) – One (1) per tooth every 5 years / Pin retention applies to permanent teeth / Re-cement of re-bond inlay / Re-cement of indirectly fabricated or prefabricated post or core re-bond

Endodontics (16b4) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

1 per tooth per life as follow: Direct or indirect pulp capping, Therapeutic pulpotomy, Pulpal debridement for primary or permanent, Root canal therapy for anterior teeth and bicuspids, retreatments for anterior teeth and bicuspids 1 per tooth per life/ retreatment of previous root canal therapy for anterior teeth, premolar molars.

Periodontics (16b5) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Root Gingival flap procedure – One (1) per quadrant every 3 years / Bone Surgery – One (1) per quadrant every 3 years Preventive full-mouth debridement – One (1) every year after the last preventive cleaning (prophylaxis)/ Periodontal scaling and root planning – One (1) service per

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quadrant every 2 years / Periodontal maintenance – Limited to one (1) every 6 months following an active periodontal treatment

Extractions (16b6) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Extraction of erupted tooth or exposed root / Surgical removal of erupted tooth / residual root / Removal of impacted tooth in soft tissue / Removal of partially or completely bony impacted tooth

Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services (16b7) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Other, Describe

Description

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Services are administered with the periodicity established by the American Dental Association (ADA).

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

Yes

Referral required for this benefit?

No

Notes

Complete or partial maxillary and mandibular denture including those held by implants 1 every 5 years (1 every 3 years for flexible base dentures)/ Dental implant to hold simple crown, fixed bridge, or complete denture / Single implants /Second stage of the implant surgery /Simple crown and fixed bridge supported by implants or implant abutments /Implant-supported complete, maxillary, or mandibular dentures / Implant removal / Implant-supported repair of complete prosthesis. Implants are limited to one (1) per life for the space the tooth replaces / Adjustments and repairs of complete or partial removable maxillary and mandibular prothesis / Rebase and reline to complete and partial removable maxillary and mandibular denture. All repairs of complete and/or partial removable dentures are limited to three repairs every 5 years / Maxillary and mandibular tissue conditioning / Incision and drainage of intraoral soft tissue abscess – One (1) per quadrant every year / Biopsy of oral soft tissue – One (1) per injury / Conscious intravenous sedation service – Limited to one (1) every 6 months / Occlusal splints / treatment of complication post-surgery / Application of desensitizing drug (on cervical or root surface) – One (1) every 6 months.

Eye Exams (17a) - Non-Medicare

Is there a maximum plan benefit coverage?

No

Is there a deductible?

No

Routine Eye Exams (17a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

EMR

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

Eyewear Exam (17a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

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.

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Eyewear (17b) - Non-Medicare

Is there a maximum plan benefit coverage?

Yes

Select the maximum plan benefit coverage type

Plan-specified amount per period

Periodicity

Every Year

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

Yes

Combined maximum amount

$600.00

Is there a deductible?

No

Contact Lenses (17b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglasses (lenses and frames) (17b2) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass lenses (17b3) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Eyeglass frames (17b4) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Upgrades (17b5) - Non-Medicare

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Exams (18a) - Non-Medicare

Is there a deductible?

No

Is there a maximum plan benefit coverage?

No

Routine Hearing Exams (18a1) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

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Fitting/Evaluation for Hearing Aid (18a2) - Non-Medicare

Is this benefit unlimited?

No

Indicate number of visits

1

Periodicity

Every Year

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Hearing Aids (18b) - Non-Medicare

Service maximum plan benefit coverage:

Yes

Select Coverage

Both ears combined

Select the maximum plan benefit coverage type

Plan-specified amount per period

Maximum amount

$1000.00

Periodicity

Every Year

Service maximum enrollee out-of-pocket cost (MOOP):

No

Is there a deductible?

No

Does your plan cover OTC hearing aids as part of your hearing aid benefit?

No

Hearing Aids (all types) (18b1) - Non-Medicare

Is this benefit unlimited?

Yes

Is there a coinsurance?

No

Is there a copayment?

No

Authorization required for this benefit?

No

Referral required for this benefit?

No

Rx

Rx Setup

Select the type of drug benefit

Actuarially Equivalent Standard

Retail

Standard/Preferred Retail

Mail-Order

Standard Mail-Order

Long-Term Care

Yes

Out-of-Network

Yes

Sponsor attests that it will comply with 42 CFR 423.154

Yes

Does this plan pay for over-the-counter-medications (OTCs) under the utilization management program? If you select "Yes" you must upload a supplemental file through the Formulary Submission Module by Friday, June 9, 2023 at 11:59 am Eastern Time.

Yes

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

Yes

Tiering

Number of tiers in the Part D benefit

6

Does this plan offer a tier model with an optional tier

Yes

Select the optional drug tier (Tier 6)

Select Care Drugs

Select Formulary Tier Model

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

What is your Formulary Exceptions Tier?

Tier 4 - Non-Preferred Brand

Does this plan apply a second less expensive cost-sharing level for all generic drugs approved for formulary exceptions?

No

Rx Cost Share

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

How does this plan apply cost-sharing before the Initial Coverage Limit (ICL) is met?

Cost Share Tiers

How does this plan apply cost-sharing beyond the Medicare Part D Annual Out-of-Pocket cost threshold?

Medicare-defined Post Threshold Cost Shares (no cost sharing)

Rx Tier Locations

Standard/Preferred Retail

Select the 1-month location supply for all tiers offered:

30

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Standard Mail-Order

Do you offer 1-Month supply?

No

Do you offer 2-Month supply?

No

Do you offer 3-Month supply?

Yes

Indicate each tier for which the location supply applies: (Select all that apply)

Tier 1 - Preferred Generic, Tier 2 - Generic, Tier 3 - Preferred Brand, Tier 4 - Non-Preferred Brand, Tier 5 - Specialty Tier, Tier 6 - Select Care Drugs

Rx Tier 1 - Preferred Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 1 Pre-ICL - Preferred Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$19.00

Daily Copayment 1-month

$0.63

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$38.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.53

3-Month Supply

Select days for 3-month supply

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90

Copayment 3-month supply

$32.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$32.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$16.00

Daily Copayment 1-month

$0.52

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$19.00

Rx Tier 1 GAP - Preferred Generic

This plan does not have additional gap cost sharing.

Rx Tier 1 Post OOP - Preferred Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 2 - Generic

Tier Drug Type(s)

Generic

Yes

Brand

No

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 2 Pre-ICL - Generic

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$20.00

Daily Copayment 1-month

$0.67

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$40.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

EMR

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$34.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$17.00

Daily Copayment 1-month

$0.55

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$20.00

Rx Tier 2 GAP - Generic

This plan does not have additional gap cost sharing.

Rx Tier 2 Post OOP - Generic

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 3 - Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 3 Pre-ICL - Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$47.00

Daily Copayment 1-month

$1.57

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$94.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.40

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$84.00

Long Term Care

Select days for long-term care supply

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31

Copayment 1-month supply

$42.00

Daily Copayment 1-month

$1.35

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$47.00

Rx Tier 3 GAP - Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 3 Post OOP - Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 4 - Non-Preferred Brand

Tier Drug Type(s)

Generic

No

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 4 Pre-ICL - Non-Preferred Brand

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$100.00

Daily Copayment 1-month

$3.33

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$200.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.17

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$190.00

Long Term Care

Select days for long-term care supply

31

Copayment 1-month supply

$95.00

Daily Copayment 1-month

$3.06

Out of Network

Select days for out of network 1-month supply

30

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Copayment 1-month supply

$100.00

Rx Tier 4 GAP - Non-Preferred Brand

This plan does not have additional gap cost sharing.

Rx Tier 4 Post OOP - Non-Preferred Brand

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 5 - Specialty Tier

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

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Select days for out of network 1-month supply

30

Rx Tier 5 Pre-ICL - Specialty Tier

Cost-Share Structure

Coinsurance

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Coinsurance 1-month supply

25%

3-Month Supply

EMR

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

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

Yes

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

Yes

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Coinsurance 3-month supply

25%

Long Term Care

Select days for long-term care supply

31

Coinsurance 1-month supply

25%

Out of Network

Select days for out of network 1-month supply

30

Coinsurance 1-month supply

25%

Rx Tier 5 GAP - Specialty Tier

This plan does not have additional gap cost sharing.

Rx Tier 5 Post OOP - Specialty Tier

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Tier 6 - Select Care Drugs

Tier Drug Type(s)

Generic

Yes

Brand

Yes

Tier Includes

Part D Drugs Only

Standard/Preferred Retail

Select days for 1-month supply

30

Select days for 3-month supply

90

Standard Mail-Order

Select days for 3-month supply

90

Long Term Care

Select days for long-term care supply

31

Out of Network

Select days for out of network 1-month supply

30

Rx Tier 6 Pre-ICL - Select Care Drugs

Cost-Share Structure

Copayment

Standard/Preferred Retail Cost Sharing

Standard Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$9.00

Daily Copayment 1-month

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$0.30

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$18.00

Preferred Retail

1-Month Supply

Select days for 1-month supply

30

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.27

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

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

Yes

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

No

Standard Mail-Order Cost Sharing

3-Month Supply

Select days for 3-month supply

90

Copayment 3-month supply

$16.00

Long Term Care

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Select days for long-term care supply

31

Copayment 1-month supply

$8.00

Daily Copayment 1-month

$0.26

Out of Network

Select days for out of network 1-month supply

30

Copayment 1-month supply

$9.00

Rx Tier 6 GAP - Select Care Drugs

This plan does not have additional gap cost sharing.

Rx Tier 6 Post OOP - Select Care Drugs

Cost-Share Structure

Copayment

Copayment

$0.00

Rx Attestations

I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.

Yes

Rx Insulin

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Indicate which tiers have insulin drugs (Select all that apply):

Tier 6 - Select Care Drugs

Rx Insulin Tier 1 Pre-ICL - Preferred Generic

This tier does not have insulin drugs.

Rx Insulin Tier 2 Pre-ICL - Generic

This tier does not have insulin drugs.

Rx Insulin Tier 3 Pre-ICL - Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 4 Pre-ICL - Non-Preferred Brand

This tier does not have insulin drugs.

Rx Insulin Tier 5 Pre-ICL - Specialty Tier

This tier does not have insulin drugs.

Rx Insulin Tier 6 Pre-ICL - Select Care Drugs

Standard/Preferred Retail

Standard Retail

Copayment 1-month supply
$9.00

Copayment 3-month supply
$18.00

Preferred Retail

Copayment 1-month supply
$8.00

Copayment 3-month supply
$16.00

Standard Mail-Order

Copayment 3-month supply
$16.00

Long-Term Care

Copayment 1-month supply
$8.00

Out-of-Network

Copayment 1-month supply
$9.00

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Rx Notes

No Data Saved for Selected Section, Incomplete or Not Started.

Rx VBID

Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?

No

Rx VBID Rewards and Incentives

No Data Saved for Selected Section, Incomplete or Not Started.

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