APPENDIX C (4)

Bid Report –

Summary of Benefits

Bid Reports 2024

PBP Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

EMR

Tiered Cost sharing for Part B Services

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

EMR

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

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**

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

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

EMR

4b Urgently Needed Services

Service Category Description

Benefit Description

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

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization

Service Category Description

Benefit Description

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

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
24-002

EMR

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 24-002

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

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

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	30
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

EMR

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Transportation Services?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

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

EMR

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices.
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

13a Acupuncture

Service Category Description

Benefit Description

Question	**Response**

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	**Response**
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	75.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

13c Meal Benefit

Service Category Description

Benefit Description

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

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

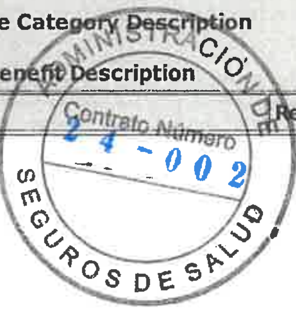
Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Benefit Description

Question	Response



14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

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

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response

14b Annual Physical Exam

Service Category Description

Benefit Description

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

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number

EMR

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative Therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors, such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

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

EMR

14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Kidney Disease Education Services?	No

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response

EMR

26/4

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

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

Benefit Description

Question	Response
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	4000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Non-routine Services 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 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 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 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.

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Periodontics 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 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 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.

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams; Other
Select type of benefit for Routine Eye Exams:	Mandatory

17a Eye Exams

Service Category Description

Benefit Description

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

EMR

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

EMR

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response

EMR

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

EMR

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	5741
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 borader 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
Description:	Health Risk Assessment, Social Work Assessment, RN Outreach Assessment and Social Determinants of Health Assessment
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

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

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

Disease States: Diabetes; Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Diabetes; Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 2 Description:	Acute Stroke
		Other 3 Description:	Abdominal, Hip, knee or open heart surg
		Other 4 Description:	COPD patients with supplemental oxygen dependency
		Other 5 Description:	Bedridden patients
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		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

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

Disease States: Diabetes; Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		In-Home Support Services Notes:*	Benefit consists of In-home Support for activities of daily living such as: Help with bathing and 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.

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

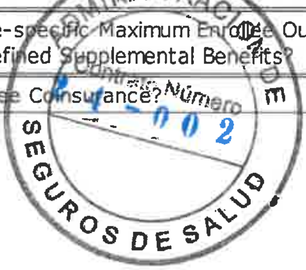
Service Category Description

Benefit Description

PBP Section	Category	Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Other 1 Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Other 1
		Other 1 Description:	Bedridden patients with specific essential services requirements
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		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.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No



ADMINISTRACIÓN DE SEGUROS DE SALUD Contrato Número 2 0 0 2

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		In-Home Support Services Notes:*	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.

19c VBID Hospice

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

EMR

19c VBID Hospice	
Question	**Response**
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
Hospice notes	In-Home Support Benefit 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.

Bid Reports 2024

PBP Part D Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Plus (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 2 - Renewal - Successfully submitted (06/02/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Part D Benefit Data	
Benefit	Plan Data
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Shares Above the Threshold	

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.53	$0.57	$1.40	$3.17		$0.27
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.30
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$18.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.52	$0.55	$1.35	$3.06		$0.26
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$9.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$18.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$9.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$8.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$8.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	

Bid Reports 2024

PBP Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services

Question	Response
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	Yes
Select the benefits that have tiered cost sharing:	Medicare-covered

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

EMR

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

EMR

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	**Response**
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	**Response**

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	**Response**

EMR

4b Urgently Needed Services

Service Category Description

Benefit Description

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

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

5 Partial Hospitalization

Service Category Description

Benefit Description

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

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes
Notes:	$0 copay for services rendered in SALUS facility. $2 copay for Medicare covered services.
Notes:	

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

EMR

7g Other Health Care Professional Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

EMR

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

10a Ambulance Services

Service Category Description

Benefit Description

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

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	12
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Transportation Services?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	10%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	10%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	10% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and non-surgically implanted prosthetic device and Cardiovascular Devices.
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	No

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

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

13c Meal Benefit

Service Category Description

Benefit Description

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

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

EMR

13g Dual Eligible SNPs with Highly Integrated Services

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Service Category Description

Benefit Description

Benefit Description

Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

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

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response

14b Annual Physical Exam

Service Category Description

Benefit Description

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

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes

EMR

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction with qualified health professionals (health educators / Nutritionist) on specific disease conditions, such as (but not limited to): Hypertension, Diabetes, Congestive Heart Failure (CHF), and smoking/tobacco use. This program provides health education material, group interventions and telephone-based education on nutrition and weight management by health educators.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

EMR

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

15 Medicare Part B Rx Drugs and Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2750.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Non-routine Services 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 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 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.

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Endodontics 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 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 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 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.

17a Eye Exams

Service Category Description

Benefit Description

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

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
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.

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

EMR

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	2142
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 borader 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

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Description:	Health risk assessment, Social work assessment, RN Outreach assessment and Social determinants of health assessments.
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	Yes
How many packages do your Additional Benefits contain? (1-15)	3

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 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
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1 Disease States: Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5 Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		In-Home Support Services Notes:*	Benefit consists of In-home Support for activities of daily living such as: Help with bathing and 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.

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Other 1 Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Other 1
		Other 1 Description:	Bedridden patients with specific essential services requirements
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No

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

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2 Disease States: Other 1 Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		In-Home Support Services 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.

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	3105
		Expected Number of Enrollees to be engaged and receive Model benefits:	3105
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Select all the Non-Medicare-covered additional benefits offered in this package:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i10: General Supports for Living; 13i1: Food and Produce; 13i6: Social Needs Benefit
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	Yes
		Specify the maximum benefit amount:	165.00
		Select the package level maximum coverage periodicity:	Every month
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i6: Social Needs Benefit; 13i10: General Supports for Living
		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.
19b - 10b	Additional Benefits for VBID/UF/SSBCI - Transportation Services	Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
		Select enhanced benefit:	Any Health-related Location
		Select type of benefit for Any Health-related Location:	Mandatory
		Is this benefit unlimited for number of trips for Any Health-related Location?	Yes
		Select Type of Transportation for Any Health-related Location:	One-way

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	165.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Transportation Services?	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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	165.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
		Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	165.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	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
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	165.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Social Needs Benefit?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		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
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Select type of benefit for General Supports for Living:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	165.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for General Supports for Living?	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.

19c VBID Hospice	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

19c VBID Hospice

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

EMR

Bid Reports 2024

PBP Part D Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Advance (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 2 - Renewal - Successfully submitted (06/02/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Part D Benefit Data	
Benefit	Plan Data
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Shares Above the Threshold	

EMR

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.53	$0.57	$1.40	$3.17		$0.27
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.30
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$18.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.52	$0.55	$1.35	$3.06		$0.26
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$9.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$18.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$9.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$8.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$8.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	

Bid Reports 2024

PBP Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

EMR

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

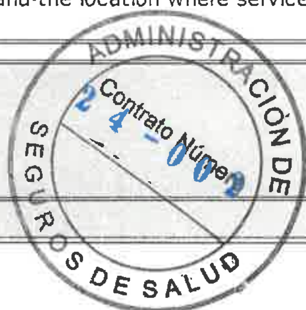
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Notes:	Services in the USA may also be available through reimbursement in accordance with Medicare rates and the location where services were provided.

4a Emergency Services

Service Category Description

Benefit Description

Question	Response



EMR

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

EMR

5 Partial Hospitalization

Service Category Description

Benefit Description

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

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

EMR

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

EMR

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

EMR

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

EMR

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

EMR

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

EMR

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

EMR

10a Ambulance Services

Service Category Description

Benefit Description

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

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	12
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

EMR

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Transportation Services?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

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

EMR

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices. 0% coinsurance for Cardiovascular Devices.
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

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

EMR

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

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

13c Meal Benefit

Service Category Description

Benefit Description

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

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

EMR

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Benefit Description

Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

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

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response

EMR

14b Annual Physical Exam

Service Category Description

Benefit Description

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

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction 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.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

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

14d Kidney Disease Education Services

Service Category Description

Benefit Description

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

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00

EMR

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

EMR

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2750.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Non-routine Services 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 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 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 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 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

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Extractions 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 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.

17a Eye Exams

Service Category Description

Benefit Description

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

EMR

17a Eye Exams

Service Category Description

Benefit Description

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

EMR

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

EMR

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response

EMR

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

EMR

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	Yes
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	No
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	3025
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 borader 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
Description:	Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	No

19b Additional Benefits for VBID/UF/SSBCI

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

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 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
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		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

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		In-Home Support Services Notes:*	Benefit consists of In-home Support for activities of daily living such as: Help with bathing and 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.

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Other 1
		Other 1 Description:	Bedridden patients with specific essential services requirements
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		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.
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No
		In-Home Support Services Notes:*	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.

19c VBID Hospice

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

19c VBID Hospice

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

EMR

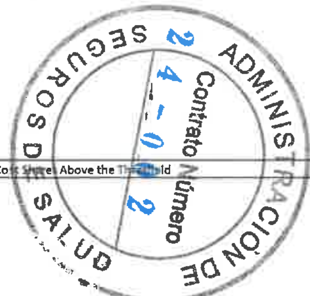
Bid Reports 2024

PBP Part D Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Blindao (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 2 - Renewal - Successfully submitted (06/02/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Part D Benefit Data	
Benefit	**Plan Data**
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Share Above the Threshold	



EMR

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.53	$0.57	$1.40	$3.17		$0.27
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.30
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$18.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.52	$0.55	$1.35	$3.06		$0.26
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$9.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$18.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$9.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$8.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$8.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	

EMR

Bid Reports 2024

PBP Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

EMR

Tiered Cost sharing for Part B Services

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-0032

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

EMR

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

EMR

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

EMR

4b Urgently Needed Services

Service Category Description

Benefit Description

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

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

EMR

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

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

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

EMR

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

EMR

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

EMR

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes

EMR

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

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

EMR

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

EMR

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

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

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

10a Ambulance Services

Service Category Description

Benefit Description

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

10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

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

EMR

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non-preferred brands and manufacturers.

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices and for Cardiovascular Devices.
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

Question	Response

ADMINISTRACIÓN DE SEGUROS DE SALUD Contrato Número 2-4-002

EMR

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

EMR

13a Acupuncture

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

EMR

13b Over-the-Counter (OTC) Items Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Plan Benefit Coverage amount:	150.00
Select Maximum Plan Benefit Coverage periodicity:	Every month
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

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

EMR

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Benefit Description

Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

EMR

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	No
Is a referral required?	No

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**

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

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número 24-002

EMR

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction 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.

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative Therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors, such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

14d Kidney Disease Education Services

Service Category Description

Benefit Description

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

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

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

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Extractions:	Mandatory

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1750.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Non-routine Services 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 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 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

EMR

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

EMR

17a Eye Exams

Service Category Description

Benefit Description

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

EMR

17a Eye Exams

Service Category Description

Benefit Description

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

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	400.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

17b Eyewear

Service Category Description

Benefit Description

Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams

Service Category Description

Benefit Description

Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

EMR

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	563
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

EMR

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
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 borader 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
Description:	Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	816
		Expected Number of Enrollees to be engaged and receive Model benefits:	816
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

EMR

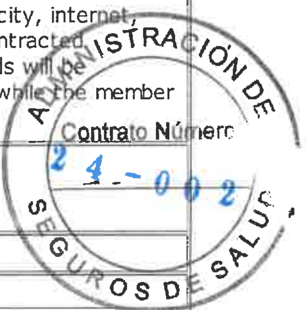
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13b: Over-the-Counter (OTC) Items; 13i10: General Supports for Living; 13i1: Food and Produce; 13i6: Social Needs Benefit; 10b2: Transportation Services - Any Health-related Location
		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
		Select the package level maximum coverage periodicity:	Every month
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i6: Social Needs Benefit; 13i10: General Supports for Living
		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.
19b - 10b	Additional Benefits for VBID/UF/SSBCI - Transportation Services	Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
		Select enhanced benefit:	Any Health-related Location
		Select type of benefit for Any Health-related Location:	Mandatory



EMR

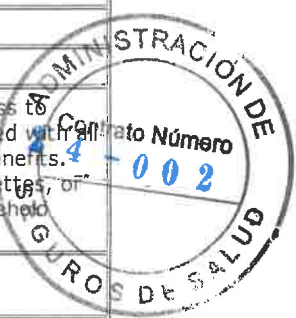
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is this benefit unlimited for number of trips for Any Health-related Location?	Yes
		Select Type of Transportation for Any Health-related Location:	One-way
		Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Transportation Services?	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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
		Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	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
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Social Needs 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
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Select type of benefit for General Supports for Living:	Mandatory



EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for General Supports for Living?	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.

19c VBID Hospice

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

EMR

19c VBID Hospice

Question	Response
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
Hospice notes	In-Home Support Benefit 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.

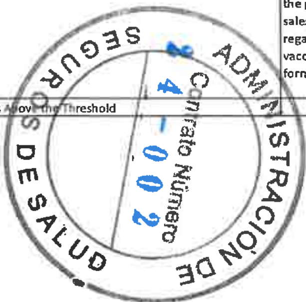
Bid Reports 2024

PBP Part D Benefits Report

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

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Enlace (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Status:	Version 2 - Renewal - Successfully submitted (06/02/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Part D Benefit Data	
Benefit	Plan Data
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Shares Above the Threshold	

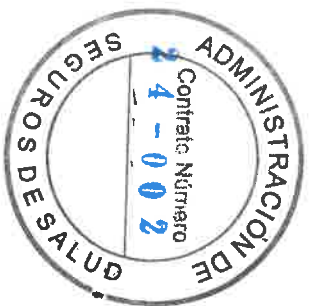


EMR

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.53	$0.57	$1.40	$3.17		$0.27
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.30
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$18.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.52	$0.55	$1.35	$3.06		$0.26
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$9.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$18.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$9.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$8.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$8.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	



Bid Reports 2024

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 036
VBID: Yes - Part C and Hospice
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Titan (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

EMR

Tiered Cost sharing for Part B Services

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

EMR

3/

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

EMR

4b Urgently Needed Services

Service Category Description

Benefit Description

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

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

EMR

5 Partial Hospitalization

Service Category Description

Benefit Description

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

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

EMR

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	Yes
Select which Chiropractic Services have a Copayment (Select all that apply):	Medicare-covered Chiropractic Services; Routine Care
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Care:	$2.00
Indicate Maximum Copayment amount per visit for Routine Care:	$2.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	No

7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes

EMR

7c Occupational Therapy Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Occupational Therapy Services?	No

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	No

7e Mental Health Specialty Services

Service Category Description

Benefit Description

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

EMR

7f Podiatry Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Foot Care
Select type of benefit for Routine Foot Care:	Mandatory
Is this benefit unlimited for Routine Foot Care?	No
Indicate number of Routine Foot Care visits:	4
Select the Routine Foot Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	Yes
Select which Podiatry Services have a Copayment (Select all that apply):	Medicare-covered Podiatry Services; Routine Foot Care
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$2.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	$2.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	No
Notes:	$0 copay for services rendered in SALUS facility. $2 copay for services rendered in the provider network.
Notes:	$0 copay for services rendered in SALUS facility. $2 copay for services rendered in the provider network.

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

EMR

7g Other Health Care Professional Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Other Health Care Professional Services?	No

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

EMR

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

Question	Response
Is a referral required for Opioid Treatment Program Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00

EMR

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

EMR

9a Outpatient Hospital Services

Service Category Description

Benefit Description

Question	Response

9b Ambulatory Surgical Center (ASC) Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Ambulatory Surgical Center Services?	No

9c Outpatient Substance Abuse Services

Service Category Description

Benefit Description

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

EMR

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

10a Ambulance Services

Service Category Description

Benefit Description

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

EMR

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	48
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Transportation Services?	No
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.

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

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	0% coinsurance for preferred brands and manufacturers. 5% coinsurance for non preferred brands and manufacturers.

11b Prosthetics/Medical Supplies

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	Yes
Select which Prosthetics/Medical Supplies have a Coinsurance (Select all that apply):	Medicare-covered Prosthetic Devices; Medicare-covered Medical Supplies
Indicate Minimum Coinsurance percentage for Medicare-covered Prosthetic Devices:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Prosthetic Devices:	5%
Indicate Minimum Coinsurance percentage for Medicare-covered Medical Supplies:	0%
Indicate Maximum Coinsurance percentage for Medicare-covered Medical Supplies:	5%
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Notes:	5% coinsurance applies to surgically implanted prosthetics devices, urinary system & neurostimulator prosthetic devices. 0% coinsurance applies to orthotics and nonsurgically implanted prosthetic devices and Cardiovascular Devices.
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.

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts

Service Category Description

Benefit Description

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

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

EMR

13a Acupuncture

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

EMR

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

13c Meal Benefit

Service Category Description

Benefit Description

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

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

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

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

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

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

EMR

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	**Response**
Is authorization required?	No
Is a referral required?	No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	**Response**

14b Annual Physical Exam

Service Category Description

Benefit Description

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

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	**Response**
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services; 14c17: Alternative Therapies*
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número
24-002

EMR

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Select type of benefit for Alternative Therapies:	Mandatory
Is this benefit unlimited for Alternative Therapies?	No, indicate number
Indicate number of visits offered for Alternative Therapies:	12
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction 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.

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home.
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.
Alternative Therapies Notes:*	Services are subject to the combined maximum limit with Acupuncture benefits. Alternative Therapies include: • Chinese Medicine • Pranic Healing • Music Therapy • Hypnotherapy (for anxiety, phobias, substance abuse, mental disorders, bad habits or undesirable behaviors, such as sleeping and learning disorders and communication issues) • Naturopathic Medicine • Traditional Chinese Medicine • Reflexology

14d Kidney Disease Education Services

Service Category Description

Benefit Description

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

EMR

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

EMR

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No
Is there an enrollee Deductible?	No
Is Authorization Required?	Yes
Does the plan offer step therapy?	Yes
Does the benefit step from (select all that apply):	Part B to Part B?; Part B to Part D?; Part D to Part B?
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	Yes

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No
Non-routine Services 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 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 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

EMR

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

EMR

17a Eye Exams

Service Category Description

Benefit Description

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

17a Eye Exams

Service Category Description

Benefit Description

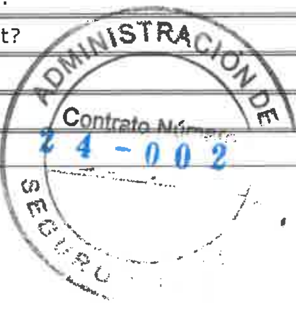
Question	Response
Notes:	Routine eye exam: Test performed by physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eye exam, consultation and prescription for eyewear including refraction.

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No



EMR

17b Eyewear

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

EMR

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs Service Category Description Benefit Description	
Question	**Response**

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	17868
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

ADMINISTRACIÓN DE SEGUROS
Contrato Número 24-002

EMR

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
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 borader 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
Description:	Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	25895
		Expected Number of Enrollees to be engaged and receive Model benefits:	25895
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i10: General Supports for Living; 13i6: Social Needs Benefit; 10b2: Transportation Services - Any Health-related Location
		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
		Select the package level maximum coverage periodicity:	Every month
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i6: Social Needs Benefit; 13i10: General Supports for Living
		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.
19b - 10b	Additional Benefits for VBID/UF/SSBCI - Transportation Services	Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
		Select enhanced benefit:	Any Health-related Location
		Select type of benefit for Any Health-related Location:	Mandatory

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is this benefit unlimited for number of trips for Any Health-related Location?	Yes
		Select Type of Transportation for Any Health-related Location:	One-way
		Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	75.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Transportation Services?	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.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	75.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	75.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is authorization required?	No
		Is a referral required for Food and Produce?	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
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	75.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Social Needs 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
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Select type of benefit for General Supports for Living:	Mandatory

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	75.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for General Supports for Living?	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

19c VBID Hospice

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

EMR

19c VBID Hospice	
Question	**Response**
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
Hospice notes	In-Home Support Benefit 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.

Bid Reports 2024

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 036
VBID: Yes - Part C and Hospice
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region: Atlanta
Lead Marketing Region: Atlanta
Org. Marketing Name: Triple S Advantage
Plan Name: Platino Titan (HMO D-SNP)
Plan Geographic Name: Puerto Rico
Status: Version 2 - Renewal - Successfully submitted (06/02/23)

Plan Type: HMO
Enrollee Type: Part A and Part B
Number of Tiers: 6
Part D Plan Premium: N/A
Continuation Area Available: No
Visitor/Travel Benefit Available: US - No
Formulary: Yes, 00024400
Part D Benefit: Yes, Actuarially Equivalent Standard
Special Needs Plan: Yes
Special Needs Plan Type: Dual-Eligible
Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? No

Standard Bid For Section B: No
Standard Bid For Section C: No
Standard Bid For Section D: No

Part D Benefit Data	
Benefit	**Plan Data**
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Shares Above the Threshold	

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.53	$0.57	$1.40	$3.17		$0.27
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.63	$0.67	$1.57	$3.33		$0.30
Standard Retail Cost-Sharing, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$38.00	$40.00	$94.00	$200.00		$18.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$19.00	$20.00	$47.00	$100.00		$9.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$32.00	$34.00	$84.00	$190.00		$16.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.52	$0.55	$1.35	$3.06		$0.26
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$16.00	$17.00	$42.00	$95.00		$8.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$9.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$18.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$9.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$8.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$8.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	

Bid Reports 2024

PBP Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 040
VBID: Yes - Part C and Hospice
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Selecto (HMO D-SNP)
Plan Geographic Name:	Platino Selecto
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully submitted (06/02/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

EMR

Tiered Cost sharing for Part B Services

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

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

1a Inpatient Hospital-Acute

Service Category Description

Benefit Description

Question	Response

EMR

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Per Admission or Per Stay
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	No
Is a referral required for Inpatient Psychiatric Hospital Services?	No

1b Inpatient Hospital-Psychiatric

Service Category Description

Benefit Description

Question	Response

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

EMR

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Do you charge cost sharing on the day of discharge?	No
Is authorization required?	Yes
Is a referral required for SNF Services?	No

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	$0.00
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	$0.00

EMR

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

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

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

4b Urgently Needed Services

Service Category Description

Benefit Description

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

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

Question	Response
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	Yes
Is the service-specific Maximum Plan Benefit Coverage amount unlimited?	No
Indicate Maximum Plan Benefit Coverage amount:	75.00
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Worldwide services are covered through reimbursement in accordance with Triple-S Advantage rates.

4c Worldwide Emergency/Urgent Coverage

Service Category Description

Benefit Description

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

5 Partial Hospitalization

Service Category Description

Benefit Description

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

6 Home Health Services

Service Category Description

Benefit Description

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

7a Primary Care Physician Services

Service Category Description

Benefit Description

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

7b Chiropractic Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	5
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	No

EMR

7c Occupational Therapy Services

Service Category Description

Benefit Description

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

7d Physician Specialist Services excluding Psychiatric Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physician Specialist Services?	No

7e Mental Health Specialty Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00

EMR

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

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

EMR

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

EMR

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No

7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

EMR

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	No

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

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

EMR

8b Outpatient Diagnostic and Therapeutic Radiological Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	No

9a Outpatient Hospital Services

Service Category Description

Benefit Description

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

EMR

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

EMR

9d Outpatient Blood Services

Service Category Description

Benefit Description

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

10a Ambulance Services

Service Category Description

Benefit Description

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

10b Transportation Services

Service Category Description

Benefit Description

Question	Response

EMR

10b Transportation Services

Service Category Description

Benefit Description

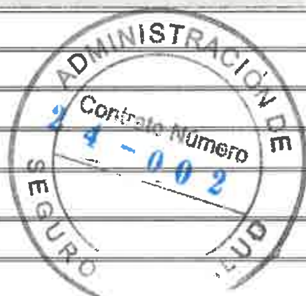
Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Any Health-related Location
Select type of benefit for Any Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Any Health-related Location?	No
Indicate number of trips for Any Health-related Location:	18
Select Any Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Any Health-related Location:	One-way
Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Transportation Services?	No

11a Durable Medical Equipment (DME)

Service Category Description

Benefit Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes



11b Prosthetics/Medical Supplies Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	$0.00
Is authorization required?	Yes

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

12 Dialysis Services

Service Category Description

Benefit Description

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

13a Acupuncture

Service Category Description

Benefit Description

Question	Response
Does the plan provide Acupuncture as a supplemental benefit under Part C?	No

13a Acupuncture

Service Category Description

Benefit Description

Question	Response

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
Select type of benefit for OTC Items:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Indicate Maximum Plan Benefit Coverage amount:	50.00
Select Maximum Plan Benefit Coverage periodicity:	Every three months

13b Over-the-Counter (OTC) Items

Service Category Description

Benefit Description

Question	Response
Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes
Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
Notes:	Analgesics Anti-Inflammatory (NSAIDs) and Non-Narcotic, Antihistamine Hypnotics, Anorectal Agents, Antidiarrheal, Antiemetic, Artificial Tears and Lubricants, Calcium, Cobalamins, Cough/Cold/Allergy, 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.

13c Meal Benefit

Service Category Description

Benefit Description

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

EMR

13d Other 1

Service Category Description

Benefit Description

Question	Response

13e Other 2

Service Category Description

Benefit Description

Question	Response

13f Other 3

Service Category Description

Benefit Description

Question	Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question	Response

13i Non-Primarily Health Related Benefits for the Chronically Ill

Service Category Description

Benefit Description

Question	Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.

EMR

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response
Is authorization required?	No
Is a referral required?	No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question	Response

14b Annual Physical Exam

Service Category Description

Benefit Description

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

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
Select enhanced benefit (Select all that apply):	14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c9: Counseling Services
Select type of benefit for Health Education:	Mandatory
Select type of benefit for Nutritional/Dietary Benefit:	Mandatory
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number
Indicate number of visits for Nutritional/Dietary Benefit:	12
Indicate setting for Nutritional/Dietary Benefit:	0
Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):	Mandatory

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Select the type of Remote Access Technologies offered (Select all that apply):	Nursing Hotline
Select type of benefit for Counseling Services:	Mandatory
Is this benefit unlimited for Counseling Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Counseling Services:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Health Education Notes:	This program provides health information and promotes healthier lifestyles. It includes interaction 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.
Remote Access Technologies (Nursing Hotline) Notes:	Teleconsulta - Nurse line for health consultations, available 24 hours, 7 days a week. If member is sick, hurt or needs health related advice, the nursing professionals will offer guidance to help him/her decide whether they should make a doctor's appointment, visit an emergency room, or will offer self-care instructions to help alleviate symptoms safely, in the comfort of their home..

EMR

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Counseling Services Notes:	Teleconsejo (Emotional Support Line) - 24/7 access to counselors trained to provide emotional support for issues such as anxiety, emotional crisis, depression, and life events, such as loss of family members or friend, economic hardship or financial issues. Health needs assessment on mental conditions and support to coordinate services or locate available community services.

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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0.00

EMR

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response
Attestation:	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.
Is there a Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:	0%
Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:	0%
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance for Insulin?	No
Is there an enrollee Copayment for Insulin?	No

EMR

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

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	No, indicate number
Indicate number of visits for Endodontics:	1
Select the Endodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	No, indicate number
Indicate number of visits for Periodontics:	1
Select the Periodontics periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	No, indicate number
Indicate number of visits for Extractions:	1
Select the Extractions periodicity:	Other, Describe
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	No, indicate number
Indicate number of visits for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	1
Select the Prosthodontics/Other Oral/Maxillofacial Surgery/Other Services periodicity:	Other, Describe

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Description:	Services are administered with the periodicity established by the American Dental Association (ADA).
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	5000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Non-routine Services 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 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 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 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 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 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

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)

Service Category Description

Benefit Description

Question	Response
Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services 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. /

17a Eye Exams

Service Category Description

Benefit Description

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

EMR

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Select the Other Service periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Indicate Minimum Copayment amount for Other Service:	$0.00
Indicate Maximum Copayment amount for Other Service:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No
Notes:	Routine eye exam: Test performed by physician to evaluate the need to have eyewear. If eyewear is needed, the plan will cover under Other eye exam, consultation and prescription for eyewear including refraction.
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.
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.

17b Eyewear

Service Category Description

Benefit Description

Question	Response

EMR

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames; Upgrades
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Select type of benefit for Upgrades:	Mandatory
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	1000.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No

18a Hearing Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)

EMR

18b Hearing Aids

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	3000.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	No
Is a referral required for Hearing Aids?	No

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

ADMINISTRACION DE SEGUROS DE SALUD
Contrato Número 24-002

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No

EMR

19a Reduced Cost Sharing for VBID/UF/SSBCI

Question	Response
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	Yes
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment; Care Management Program; In-home Assessments
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Electronic Health Records/Electronic Medical Records; Provider/Patient portals; Health Information Exchanges; Data Warehouses
Expected Number of Beneficiaries to be Engaged Annually:	3182
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 borader 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
Description:	Health risk assessment Social work assessment RN Outreach assessment Social determinants of health assessments
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes

19b Additional Benefits for VBID/UF/SSBCI

Question	Response
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI

Question	Response
How many packages do your Additional Benefits contain? (1-15)	3

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Chronic Obstructive Pulmonary Disease (COPD); Congestive Heart Failure (CHF); Other 1; Other 2; Other 3; Other 4; Other 5
		Other 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
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		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
19b - 14c	Additional Benefits for VBID/UF/SSBCI - Other Defined Supplemental Benefits	Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?	Yes
		Select enhanced benefit (Select all that apply):	14c21: In-Home Support Services
		Select type of benefit for In-Home Support Services:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other Defined Supplemental Benefits?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 1

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

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		In-Home Support Services Notes:*	Benefit consists of In-home Support for activities of daily living such as: Help with bathing and 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.

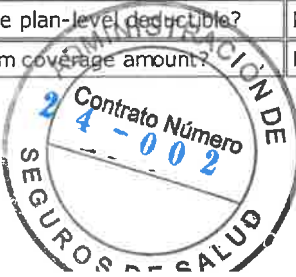
19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	MA Uniformity Flexibility
		Which disease states does this benefit apply? (Select all that apply):	Other 1
		Other 1 Description:	Bedridden patients with specific essential services requirements
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	14c21: In-Home Support Services
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No



EMR

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

EMR

19b Additional Benefits for VBID/UF/SSBCI - UF Package 2

Disease States: Other 1

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		In-Home Support Services 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.

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

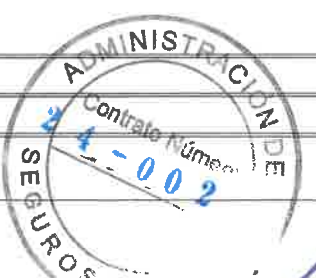
Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	4611
		Expected Number of Enrollees to be engaged and receive Model benefits:	4611
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Select all the Non-Medicare-covered additional benefits offered in this package:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i10: General Supports for Living; 13i1: Food and Produce; 13i6: Social Needs Benefit
		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
		Select the package level maximum coverage periodicity:	Every month
		Indicate mode of delivery for maximum coverage amount:	Debit Card
		Select the Non-Medicare-covered benefits that apply to the package level maximum coverage:	10b2: Transportation Services - Any Health-related Location; 13b: Over-the-Counter (OTC) Items; 13i1: Food and Produce; 13i6: Social Needs Benefit; 13i10: General Supports for Living
		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.
19b - 10b	Additional Benefits for VBID/UF/SSBCI - Transportation Services	Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
		Select enhanced benefit:	Any Health-related Location
		Select type of benefit for Any Health-related Location:	Mandatory
		Is this benefit unlimited for number of trips for Any Health-related Location?	Yes



19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Select Type of Transportation for Any Health-related Location:	One-way
		Select Mode of Transportation for Any Health-related Location:	Taxi; Van; Other, Describe
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Transportation Services?	No
		Notes:	Other methods of transportation are available, such as an automobile through a contracted provider.
19b - 13b	Additional Benefits for VBID/UF/SSBCI - Over-the-Counter (OTC) Items	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	Yes
		Select type of benefit for OTC Items:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Does your Maximum Plan Benefit Coverage amount carry forward to the next period if it is unused?	Yes
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Are you offering Nicotine Replacement Therapy (NRT) as a Part C OTC benefit?	Yes

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Nicotine Replacement Therapy (NRT) Attestation:	The Nicotine Replacement Therapy (NRT) being offered does not duplicate any Part D OTC or formulary drugs.
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Does this cover all of the OTC list which may be found in Chapter 4 of the Medicare Managed Care Manual?	No
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Social Needs Benefit; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	No

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		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
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Social Needs 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
		Does the plan provide General Supports for Living as a supplemental benefit under Part C?	Yes
		Select type of benefit for General Supports for Living:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	40.00

ADMINISTRACIÓN DE SEGUROS DE SALUD
Contrato Número
24-002

EMR

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 3

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for General Supports for Living?	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.

19c VBID Hospice

Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Coinsurance?	No
Are you offering hospice supplemental benefits?	Yes
Is there a max plan benefit amount?	No
Are hospice supplemental benefits contingent upon receiving services from an in-network provider?	Yes
Coverage of primarily and non-primarily health related items to ameliorate the functional/psychological impact of hospice enrollees' health conditions and reduce avoidable emergency and healthcare utilization.	No

19c VBID Hospice	
Question	**Response**
Temporary coverage of room and board in a residential facility as determined by a beneficiary's need for custodial and activities of daily living care without a caregiver or other residence to discharge to.	No
Reduced cost sharing for unrelated medical care services received during hospice election	No
Other mandatory supplemental benefits	Yes
Describe other mandatory supplemental benefits:	In-Home Support
Hospice notes	In-Home Support Benefit 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.

Bid Reports 2024

PBP Part D Benefits Report

TRIPLE S ADVANTAGE, INC.
H5774 - 040
VBID: Yes - Part C and Hospice
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	Atlanta
Lead Marketing Region:	Atlanta
Org. Marketing Name:	Triple S Advantage
Plan Name:	Platino Selecto (HMO D-SNP)
Plan Geographic Name:	Platino Selecto
Status:	Version 2 - Renewal - Successfully submitted (06/02/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	6
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024400
Part D Benefit:	Yes, Actuarially Equivalent Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	No
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Part D Benefit Data	
Benefit	Plan Data
Deductible	$545.00
Initial Coverage Limit	5030.00
Enrollee Out-of-Pocket Cost Threshold	
OON cost sharing structure	
You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program	Yes
OTC Medication Attestation statement: Per the CY 2009 Call Letter, an MAO cannot offer the same OTC drug under both its Part C supplemental benefit and its Part D benefit. I attest any OTC drugs that are covered under Part C are separate and distinct from OTC drugs covered under Part D.	Attest
Offers OTCs as a part of a formal Step Therapy Protocol submitted for review and approval by CMS?	
Pharmacy Network Components	Standard/Preferred Retail; Out-of-Network; Standard Mail-Order; Long-Term Care
Formulary Exception Tier	4
Do you apply a second less expensive cost sharing level for all generic drugs approved for formulary exceptions?	No
Notes Available	No
Sponsor attestation	Sponsor attests that it will comply with 42 CFR 423.154.
Indicate which tiers have insulin drugs (Select all that apply):	Tier 6
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:	
Vaccine Attestation:	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.
Cost Shares Above the Threshold	

Pre-Initial Coverage Limit						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
All drugs on formulary for this tier available at extended days supply	Yes	Yes	Yes	Yes	Yes	Yes
Drugs available at an extended day supply for this tier limited to a 1-month supply for the first fill?	No	No	No	Yes	Yes	No
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Coinsurance	Copayment
Daily Preferred Retail Copayment	$0.37	$0.40	$1.40	$3.17		$0.23
Standard Retail/Preferred Retail Cost-Sharing, 1 Month =	30	30	30	30	30	30
Preferred Retail Cost-Sharing, 1 Month Copay	$11.00	$12.00	$42.00	$95.00		$7.00
Preferred Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail/Preferred Retail Cost-Sharing, 3 Months =	90	90	90	90	90	90
Preferred Retail Cost-Sharing, 3 Month Copay	$22.00	$24.00	$84.00	$190.00		$14.00
Preferred Retail Cost-Sharing, 3 Month Coinsur					25%	
Daily Standard Retail Copayment	$0.53	$0.57	$1.57	$3.33		$0.27
Standard Retail Cost-Sharing, 1 Month Copay	$16.00	$17.00	$47.00	$100.00		$8.00
Standard Retail Cost-Sharing, 1 Month Coinsur					25%	
Standard Retail Cost-Sharing, 3 Month Copay	$32.00	$34.00	$94.00	$200.00		$16.00
Standard Retail Cost-Sharing, 3 Month Coinsur					25%	
Out-of-Network Pharmacy, 1 Month =	30	30	30	30	30	30
Out-of-Network Pharmacy, 1 Month Copay	$16.00	$17.00	$47.00	$100.00		$8.00
Out-of-Network Pharmacy, 1 Month Coinsur					25%	
Standard Mail Order Cost-Sharing, 3 Months =	90	90	90	90	90	90
Standard Mail Order Cost-Sharing, 3 Month Copay	$22.00	$24.00	$84.00	$190.00		$14.00
Standard Mail Order Cost-Sharing, 3 Month Coinsur					25%	
Daily Long Term Care Pharmacy Copayment	$0.35	$0.39	$1.35	$3.06		$0.23
Long Term Care Pharmacy, 1 Month =	31	31	31	31	31	31
Long Term Care Pharmacy, 1 Month Copay	$11.00	$12.00	$42.00	$95.00		$7.00
Long Term Care Pharmacy, 1 Month Coinsur					25%	
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:						$8.00
Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:						$16.00
Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:						$14.00
Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:						$8.00
Indicate Insulin Copayment amount for Preferred Mail Order one month supply:						$7.00
Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:						$7.00

Above Threshold						
Descriptor	Tier 1	Tier 2	Tier 3	Tier 4	Tier 5	Tier 6
Tier Label	Preferred Generic	Generic	Preferred Brand	Non-Preferred Brand	Specialty Tier	Select Care Drugs
Tier Drug Type	Generic	Generic	Brand	Brand	Generic; Brand	Generic; Brand
Tier Includes	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only	Part D Drugs Only
Type of cost sharing structure	Copayment	Copayment	Copayment	Copayment	Copayment	Copayment
Copay	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

VBID - Part D Benefit Data	
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and Incentives under the VBID Model?	No
How many packages does your Part D VBID benefit contain?	
Does your VBID benefit include Part D reductions in cost?	
Value Based Insurance Design Attestation	