



SUMMARY OF BENEFITS 2023

- **ÓPTIMO PLUS** (PPO)
- **ÓPTIMO XTRA** (PPO)



WHAT INFORMATION WILL YOU FIND IN THIS DOCUMENT?

This is a summary of your benefits. We present some of the most important benefits and services we offer. In addition, we include the cost-sharing (copay/coinsurance) that you might have to pay for certain services, depending on your plan.

To get the complete information about your plan, give us a call and ask for your Evidence of Coverage.



We are with you at every step of your care with benefits and services to take care of you.



13 service centers around the island to serve you



Triple-S Contigo
Prevention, education and entertainment programs exclusive for you



Over 13,000 providers to take care of you

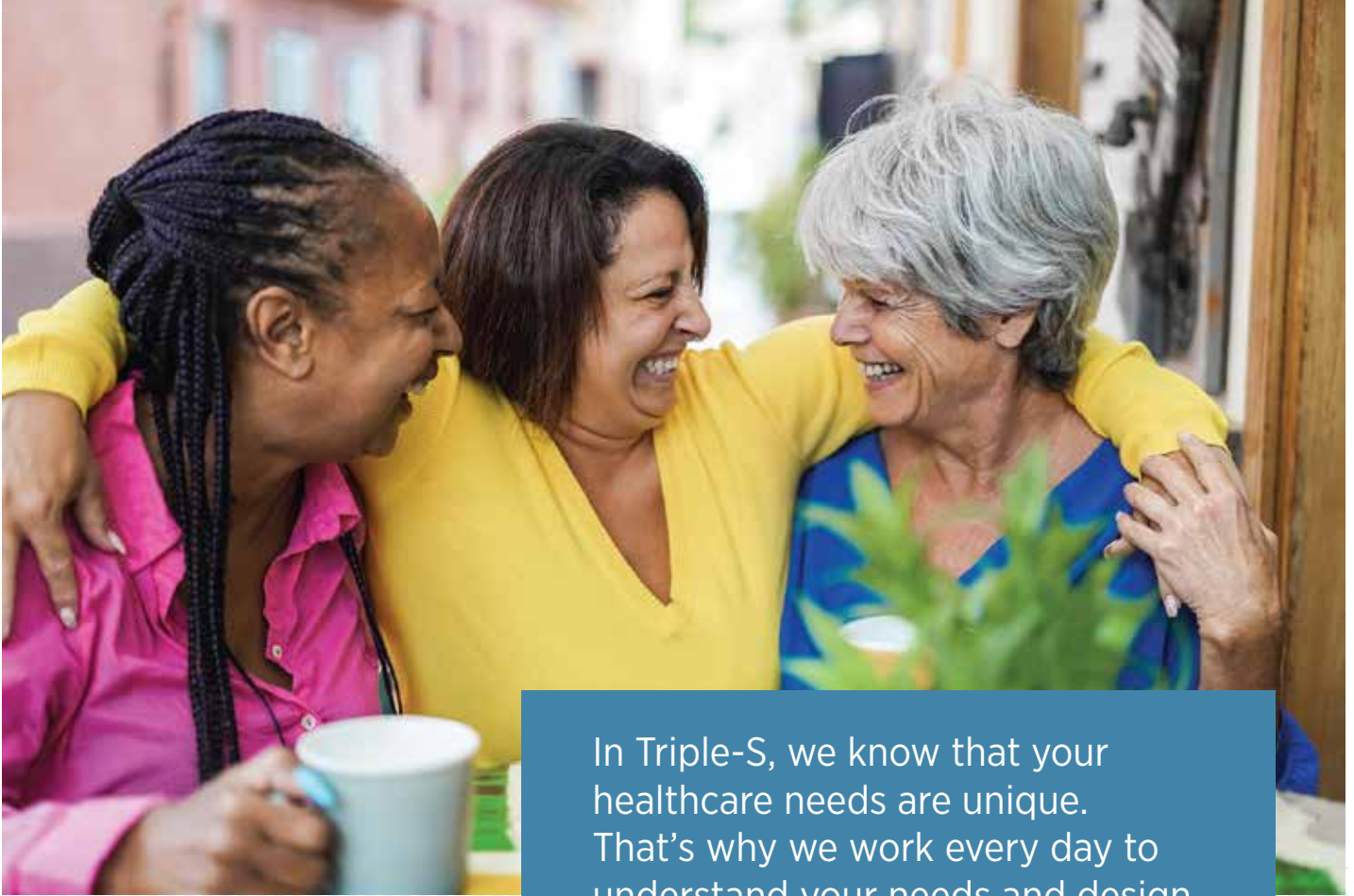
- Primary Care Physicians
- Specialists
- Laboratories
- Imaging Centers
- Pharmacies
- And more



Digital Tools
To facilitate your access to specialists and prescription drugs, among others



PPO PLANS



In Triple-S, we know that your healthcare needs are unique. That's why we work every day to understand your needs and design products that offer a variety of services and benefits that suits the needs of each individual. It is important for us that you understand all of your options and that you choose the one that better meets your health care, economic needs, as well as your lifestyle. Here, we present you some coverages that we have available for you.



A PLAN FOR EVERY NEED



ÓPTIMO PLUS
(PPO)

A plan that gives you the freedom to visit providers inside and out of network in Puerto Rico and United States, without referral. **Óptimo Plus** (PPO) is a plan with \$0 monthly premium, accessible copayments, and some supplemental benefits to take care of your health like: eyeglasses, dental procedures, and transportation.

NEW!



ÓPTIMO XTRA
(PPO)

A new coverage with free access to visit providers inside and outside of network in Puerto Rico and United States, without referrals. **Óptimo Xtra** (PPO) offers low copays to take care of your health, savings and supplemental benefits like eyeglasses, dental procedures, among others.



LEARN ABOUT THE BENEFITS OF HAVING A **MEDICARE ADVANTAGE PLAN**



When you enroll into a **Medicare Advantage** plan, you will have benefits in addition to Original Medicare that help you save money while taking better care of your health.



OTC* BENEFIT

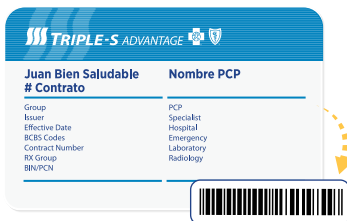


3 easy and quick options to use.



DELIVERY TO YOUR HOME

With the app you can order your prescription drugs and OTC's and get them wherever you want, at no additional cost. **Download the app today!**



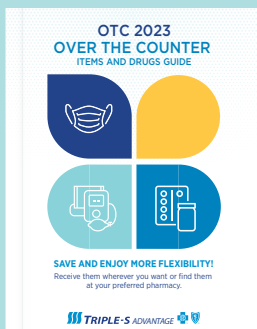
AT THE PHARMACY, THE SAME DAY

Buy and take them with you on the same day at hundreds of community pharmacies by paying at the cash register with the barcode on your plan ID card.



AT YOUR PHARMACY, AT THE PRESCRIPTION COUNTER

In those pharmacies that do not have the barcode system, you can take your OTC's at the prescription counter as you have always done.



OTC GUIDE, MORE FLEXIBLE

Take the ones you prefer with no restrictions on sizes, formats or brands.

For your convenience, the guide is organized by categories and types of products, and we include examples of some covered brands as reference. Many more are covered, if you have questions, ask your pharmacist or call us.

Scan and download the guide here →



*Applies to some plans. Amounts vary by plan.

SMILE AND GET TO WHERE EVER YOU NEED TO



\$0 copay

Dental Procedures*

- Crowns
- Root canal
- Full and partial dentures
- Periodontics
- Endodontics
- Implants in full dentures
- **NEW!** Implants in individual crowns

PON
a tu salud 

**We help you get
to where you need
to go to take care
of you**

With the trips on your coverage you can go to health care destinations such as:

- Medical appointments
- Laboratories
- Imaging centers
- Pharmacies
- Hospitals

Without pre-authorization, coordinate with time with the contracted company of your preference.



*Maximum amount of comprehensive dental benefit varies by coverage.

DIGITAL TOOLS

Your health at the palm of your hand

DELIVERY OF MEDICATIONS



- Submit prescriptions electronically
- Order OTC items
- Receive them at your home or wherever you need, with no delivery cost
- Receive alerts when you need refills of your medications
- Easy payment with credit card or *ATH Móvil*



YOUR CLINICAL PROFILE WHEREVER YOU ARE



New App!



Mi TRIPLE-S

Information about your plan in one place.

- Have your plan ID card with you always
- Easy access to the providers directory
- Access your medical service history

WE ARE WITH YOU HAND IN HAND



During and after a hospitalization we help you to complete that transition of care from the hospital to your home to avoid a relapse.



- We coordinate your follow-up medical appointments and the services or equipment recommended by your doctor to recover at home.
- We make sure that you have your prescriptions or medications when you leave the hospital.
- We have our staff at the hospital to help speed-up the communication with the medical team.
- We provide you with educational materials about your condition and recovery process.
- We provide you with a kit to make your stay at the hospital more comfortable.

Available in some of our Preferred Network of Hospitals.

Help to control your diabetes

With the programs “**Gánale a la diabetes**” and “**Yo controlo mi diabetes**” we provide you with information to empower you to take optimal care of this condition.

For more information call:
787-277-6571.



SUMMARY OF BENEFITS

SUMMARY OF BENEFITS 2023

Important

This Summary of Benefits contains information on the following Triple-S Advantage plans:

- Óptimo Plus (PPO)
- Óptimo Xtra (PPO)

Please refer to the coverage you chose during the enrollment process.

ABOUT THIS PLAN

These are Medicare Advantage PPO plans with a Medicare contract. Enrollment in the plan depends on contract renewal.

Triple-S Advantage, Inc. is a preferred provider organization (PPO), with a Medicare contract. Enrollment in Triple-S Advantage, Inc. depends on contract renewal.

To enroll in **any of these plans** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, be a citizen of or lawfully present in the United States and live in our service area. Our service area includes the 78 municipalities in Puerto Rico.

Triple-S Advantage, Inc. is an independent licensee of the BlueCross BlueShield Association.

GETTING CARE

These plans have a network of doctors, hospitals, pharmacies, and other providers.

Out-of-network/non-contracted providers are under no obligation to treat Triple-S Advantage, Inc. members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of-network services. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for an organizational determination before you receive the service.

You can go to www.sssadvantage.com to see your plan's Provider and Pharmacy Directories. You can also view the complete plan Formulary (list of Part D prescription drugs) to see which drugs are covered and if there are any restrictions.



SUMMARY OF BENEFITS

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

IF YOU HAVE QUESTIONS

For more information, call us toll-free at our Member Service Center at 1-888-620-1919 (TTY/TDD 1-866-620-2520). If you are not a member of our plan, you can call toll-free at 1-877-207-8777 (TTY/TDD 1-866-620-2520). You can call us Monday through Sunday from 8:00 a.m. to 8:00 p.m., Atlantic standard time. You can also visit our webpage at www.sssadvantage.com.

If you want to know more about the coverage and costs of Original Medicare, look in your current “Medicare & You” handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users must call 1-877-486-2048.

NON DISCRIMINATION NOTICE

This document is available for free in Spanish.

It is also available in alternate formats such as braille, large print, and audio. Please contact Member Services if you need plan information in another format or language.

COVERED BENEFITS AND LIMITATIONS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service we cover or list every limitation or exclusion. To get a complete list of covered services, request the Evidence of Coverage by calling Member Services or visiting our website at www.sssadvantage.com.

With the plan that you chose, you have the option of visiting out-of-network providers. Note that cost-sharing for these services may be higher.

Out-of-network covered services may be subject to reimbursement. Payments will be subject to the service being covered and medically necessary, and the rate to be paid for the service will not necessarily be the rate presented by the provider that rendered the service, minus the corresponding coinsurance of your plan coverage and following the monetary limits of each benefit. Plans may offer supplemental benefits in addition to Part C and Part D benefits.

Benefits, premiums, and/or copays/coinsurance may change on January 1st of every year.

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SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Monthly Plan Premium You must continue to pay your Medicare Part B premium.</p>	<p>\$0 monthly premium.</p>	<p>\$40 monthly premium.</p>
<p>Deductible These plans have no deductible</p>	<p>You pay nothing.</p>	<p>You pay nothing.</p>
<p>Maximum Out-of-Pocket Costs (does not include prescription drugs).</p> <p>The maximum amount you will pay in copayments, coinsurance, and other expenses for medical services during the year.</p>	<p>\$6,700 for services you receive from in-network providers, annually.</p> <p>\$10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</p>	<p>\$6,700 for services you receive from in-network providers, annually.</p> <p>\$10,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit.</p>
<p>Inpatient Hospital Care This plan covers an unlimited number of days for an inpatient hospital stay.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>
<p>Outpatient Hospital Coverage</p> <p>Observation Care Some services may require prior authorization</p>	<p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Ambulatory Surgery:</p> <ul style="list-style-type: none"> Ambulatory surgery center Ambulatory facility in a hospital <p>Some services may require prior authorization</p>	<p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$35 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>
<p>Doctor Visits:</p> <ul style="list-style-type: none"> Primary Care Physician Specialist Surgeries and/or procedures in a physician's office (may require prior authorization) 	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Preventive Care (e.g., flu vaccine, screening for diabetes). screening for diabetes)</p> <p>Any additional preventive services that are approved by Medicare during the year will be covered.</p>	<p>You pay nothing.</p>	<p>You pay nothing.</p>
<p>Emergency Care If you are admitted to the hospital within 24 hours for the same condition for which you were evaluated in the emergency room, you pay nothing for the emergency room visit.</p> <p>Services in the United States may also be handled through reimbursement according to Medicare rates and the location where the services were provided, minus copayment.</p>	<p>\$50 copay.</p>	<p>\$50 copay.</p>
<p>Urgently Needed Services Services in the United States may also be managed through reimbursement according to Medicare rates and the location where the services were provided, minus the copay.</p>	<p>You pay nothing.</p>	<p>You pay nothing.</p>
<p>Diagnostic Services / Laboratories / Imaging:</p> <ul style="list-style-type: none"> • Diagnostic Radiology Services (e.g. MRI) <ul style="list-style-type: none"> ▪ General ▪ Complex 	<p>In-Network: 10% coinsurance. Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$25 copay. Out-of-Network: 20% coinsurance.</p>	<p>In-Network: 10% coinsurance. Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$25 copay. Out-of-Network: 20% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<ul style="list-style-type: none"> • Laboratory Service • X-Rays • Diagnostic tests and procedures • Therapeutic Radiology services <p>Some services may require prior authorization</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>
<p>Hearing Services:</p> <ul style="list-style-type: none"> • Hearing exam 	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<ul style="list-style-type: none"> Routine hearing exam (One (1) routine hearing exam every year) Hearing aid fitting / evaluation (One (1) routine hearing exam every year) Hearing aids 	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing. Up to \$300 per year.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing. Up to \$1,000 per year.</p>
<p>Dental Services:</p> <ul style="list-style-type: none"> Preventive: Oral exam, cleaning, Fluoride and X-rays <ul style="list-style-type: none"> One (1) cleaning every six months. Dental X-ray One (1) Fluoride treatment every six months. One (1) oral exam every six months. Comprehensive: May require prior authorization. Covered services include but are not limited to restorations, periodontics, prosthodontics, endodontics (root canal) and dental implants. A maximum benefit limit applies for some services. 	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>Up to \$1,250 coverage limit per year.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>Up to \$3,250 coverage limit per year.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Vision Services:</p> <ul style="list-style-type: none"> • Eye exam (one (1) per year) • Routine eye exam (one (1) per year) • One pair of eyeglasses or contact lenses after every cataract surgery • Eyeglasses (frame & lenses), contact lenses. 	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing.</p> <p>You pay nothing. Up to \$400 per year.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>You pay nothing.</p> <p>You pay nothing. Up to \$400 per year.</p>
<p>Mental Health Services:</p> <ul style="list-style-type: none"> • Inpatient (up to one hundred ninety (190) days in a psychiatric hospital for life) • Individual therapy visits 	<p>In-Network: \$25 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: \$25 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<ul style="list-style-type: none"> Group therapy visits Partial hospitalization (some services may require prior authorization) 	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 20% coinsurance.</p> <p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>
<p>Skilled Nursing Facility (SNF) Up to one hundred (100) days in an SNF per benefit period. A previous hospital stay is not required. Requires prior authorization</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>
<p>Physical Therapy Services provided at Comprehensive Ambulatory Rehabilitation Centers (CORFs), require prior authorization. These services are subject to Medicare-set caps for rehabilitation services. Ask your provider to validate if the service you need is available.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>
<p>Ambulance Non-emergent transportation requires prior authorization.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Transportation</p> <p>One way trips for medical destinations.</p>	<p>You pay nothing.</p> <p>Up to 24 trips per year.</p>	<p>You pay nothing.</p> <p>Up to 24 trips per year.</p>
<p>Medicare Part B Drugs</p> <ul style="list-style-type: none"> • Respiratory therapy drugs • Other Part B drugs <p>Some services may require prior authorization. Step Therapy may apply for: Part B to Part B, Part B to Part D, Part D to Part B.</p>	<p>In-Network : You pay nothing. Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance. Out-of-Network: 20% coinsurance.</p>	<p>In-Network : You pay nothing. Out-of-Network: 20% coinsurance.</p> <p>In-Network: 10% coinsurance. Out-of-Network: 20% coinsurance.</p>
<p>Rehabilitation Services:</p> <ul style="list-style-type: none"> • Occupational therapy visit • Speech / language therapy visit <p>Services provided at Comprehensive Ambulatory Rehabilitation Centers (CORFs), require prior authorization. These services are subject to Medicare-set caps for rehabilitation services. Ask your provider to validate if the service you need is available.</p>	<p>In-Network: \$5 copay. Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay. Out-of-Network: 25% coinsurance.</p>	<p>In-Network: \$5 copay. Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay. Out-of-Network: 25% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Foot Care (Podiatry Services):</p> <ul style="list-style-type: none"> • Foot exams and treatment • Routine foot care (Up to six (6) visits per year including the initial visit) 	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>You pay nothing at SALUS Clinics. Other providers are available in our network.</p>
<p>Medical Equipment and Supplies:</p> <ul style="list-style-type: none"> • Durable Medical Equipment (e.g., wheelchairs, oxygen) • Prosthetics (e.g. braces, artificial limbs): <ul style="list-style-type: none"> ▪ Braces, prosthesis not surgically implanted, and cardiovascular devices ▪ Surgically implanted prosthesis, urinary system, and neuro-stimulating prosthetic device 	<p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network : You pay nothing.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p>	<p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network : You pay nothing.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<ul style="list-style-type: none"> Medical supplies Supplies for diabetes <p>Some durable medical equipment, prosthetics and medical supplies may require prior authorization.</p>	<p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network : You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>	<p>In-Network: 10% coinsurance.</p> <p>Out-of-Network: 30% coinsurance.</p> <p>In-Network : You pay nothing.</p> <p>Out-of-Network: 20% coinsurance.</p>
<p>Wellness Program:</p> <ul style="list-style-type: none"> Gym membership. (Submit your reimbursement request with the original invoice.) Wellness Program It provides health education materials, group interventions, and telephone education on nutrition and weight management based on your health profile. Teleconsulta Nursing line for health consultations, available 24 hours a day, 7 days a week. Members can call 1-800-255-4375. Teleconsejo Emotional support line available 24 hours a day, 7 days a week. Members can call 1-877-879-5964. 	<p>Up to \$25 monthly.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>	<p>Up to \$25 monthly.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

PREMIUM AND BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Chiropractic:</p> <ul style="list-style-type: none"> • Visits covered by Medicare to correct subluxation • Routine visits <p>Up to six (6) routine visits, per year, including the initial visit.</p> <p>Manipulation of the spine to correct subluxation (when one or more of your spine bones move out of position)</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p> <p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>
<p>Additional Telemedicine Services:</p> <ul style="list-style-type: none"> • Consultations with a Primary Care Physician • Consultations with Specialists • Consultations for Kidney Condition Education Services • Diabetes Self-Management Training Consultations • Individual Consultations with a Psychiatrist or Psychologist. <p>Contact your doctor to validate if you offer additional Telemedicine services and provide you with information about the means of contact to use. These services are not covered out of network.</p>	<p>You pay nothing.</p> <p>\$5 copay.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p>	<p>You pay nothing.</p> <p>\$5 copay.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p>

SUMMARY OF BENEFITS

Outpatient Prescription Drugs

Our plans group every drug in one of six (6) cost-sharing tiers. The amount you pay depends on the pharmacy you choose and when you change from one stage to another within the Part D benefit (Initial Coverage Stage, Gap Coverage Stage and Catastrophic Coverage Stage).

For additional information on pharmacy cost-sharing and the benefit stages, please call us or access the Evidence of Coverage on our webpage.

Deductible:

These plans do not have a deductible.

Stage 1: Initial Coverage Stage

What you pay until the total amount for the prescription drugs you have filled reaches \$4,660.

Remember to refer to the plan you chose

DRUG TIER (Initial Coverage Stage)	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
Tier 1 – Preferred Generics Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p> <p>\$10 copay.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p> <p>\$10 copay.</p>
Tier 2 – Non-Preferred Generics Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

DRUG TIER (Initial Coverage Stage)	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p style="text-align: center;">\$8 copay.</p> <p style="text-align: center;">\$16 copay.</p>	<p style="text-align: center;">\$8 copay.</p> <p style="text-align: center;">\$16 copay.</p>
Tier 3 – Preferred Brand Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p style="text-align: center;">\$25 copay.</p> <p style="text-align: center;">\$50 copay.</p> <p style="text-align: center;">\$50 copay.</p> <p style="text-align: center;">\$40 copay.</p> <p style="text-align: center;">\$80 copay.</p>	<p style="text-align: center;">\$15 copay.</p> <p style="text-align: center;">\$30 copay.</p> <p style="text-align: center;">\$30 copay.</p> <p style="text-align: center;">\$40 copay.</p> <p style="text-align: center;">\$80 copay.</p>
Tier 4 – Non-Preferred Brand Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p style="text-align: center;">\$40 copay.</p> <p style="text-align: center;">\$80 copay.</p> <p style="text-align: center;">\$80 copay.</p> <p style="text-align: center;">\$55 copay.</p> <p style="text-align: center;">\$110 copay.</p>	<p style="text-align: center;">\$30 copay.</p> <p style="text-align: center;">\$60 copay.</p> <p style="text-align: center;">\$60 copay.</p> <p style="text-align: center;">\$55 copay.</p> <p style="text-align: center;">\$110 copay.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

DRUG TIER (Initial Coverage Stage)	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
Tier 5 – Specialty Drugs Preferred Retail and Standard Pharmacy. <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order	<p>33% coinsurance.</p> <p>33% coinsurance.</p> <p>33% coinsurance.</p>	<p>33% coinsurance.</p> <p>33% coinsurance.</p> <p>33% coinsurance.</p>
Tier 6 – Select Care Drugs Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$3 copay.</p> <p>\$6 copay.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$3 copay.</p> <p>\$6 copay.</p>

Stage 2: Gap Coverage Stage

What you pay until your yearly out-of-pocket payments reach \$7,400. During the Gap Coverage Stage, you pay no more than 25% of the cost for your generic and brand drugs (in addition to a part of the supply cost).

However, you receive a certain degree of coverage for prescription drugs as described in the following table.

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

DRUG TIER (Gap Coverage Stage)	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
Tier 1 – Preferred Generics Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p> <p>\$10 copay.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$5 copay.</p> <p>\$10 copay.</p>
Tier 2 – Non-Preferred Generics Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$8 copay.</p> <p>\$16 copay.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$8 copay.</p> <p>\$16 copay.</p>

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

DRUG TIER (Gap Coverage Stage)	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
Tier 6 – Select Care Drugs Preferred Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply Mail Order Standard Retail Pharmacy <ul style="list-style-type: none"> • 30-day supply • 90-day supply 	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$3 copay.</p> <p>\$6 copay.</p>	<p>You pay nothing.</p> <p>You pay nothing.</p> <p>You pay nothing.</p> <p>\$3 copay.</p> <p>\$6 copay.</p>

Stage 3: Catastrophic Coverage Stage

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$7,400 limit for the calendar year. During this stage, the plan will pay for most of the cost of your drugs.

- Your part of the cost for a covered drug will be the highest amount of:
 - 5% coinsurance of the cost for the drug;
 - Or, \$4.15 for a generic drug, or a drug treated as generic, and \$10.35 for all other drugs.
- Our plan pays the rest of the cost.

SUMMARY OF BENEFITS

Remember to refer to the plan you chose

SUPPLEMENTAL BENEFITS	ÓPTIMO PLUS (PPO)	ÓPTIMO XTRA (PPO)
<p>Over-the-Counter Drugs and Items (OTC)</p>	<p>Not covered.</p>	<p>You pay nothing.</p> <p>\$75 every three months non-cumulative.</p> <p>Refer to the Guide for Over-the -Counter (OTC) Drugs and Items for detail of categories covered.</p>
<p>Erectile Dysfunction Drugs</p> <p>Sildenafil Citrate (25, 50 and 100 mg) Tadalafil (10 and 20 mg)</p> <p>Viagra (25, 50 and 100 mg) Cialis (10 and 20 mg)</p> <p>Up to six (6) pills monthly</p>	<p>Tier 2: Generics.</p> <p>Tier 4: Non-Preferred Brand.</p>	<p>Tier 2: Generics.</p> <p>Tier 4: Non-Preferred Brand.</p>
<p>Alternative Medicine / Acupuncture</p> <p>Up to twelve (12) combined visits each year.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>	<p>In-Network: \$5 copay.</p> <p>Out-of-Network: 25% coinsurance.</p>
<p>Nutritional / Dietary Benefit</p> <p>A maximum of twelve (12) individual visits per year to a nutritionist.</p>	<p>You pay nothing.</p>	<p>You pay nothing.</p>
<p>Blood Pressure Monitor</p> <p>One every five (5) years.</p>	<p>You pay nothing.</p>	<p>You pay nothing. (Covered through OTC benefit.)</p>

SUMMARY OF BENEFITS

Triple-S Advantage Inc. cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo.

Triple-S Advantage Inc. 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Triple-S Advantage Inc. complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATENCIÓN: si usted habla español, servicios de asistencia lingüística están disponibles libre de cargo para usted. Llame al: 1-888-620-1919 (TTY: 1-866-620-2520).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-888-620-1919 (TTY: 1-866-620-2520)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-888-620-1919 (TTY: 1-866-620-2520).

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-620-1919 (TTY 1-866-620-2520).

UNDERSTANDING THE BENEFITS

- _____ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services that you routinely see a doctor. Visit www.sssadvantage.com or call 1-888-620-1919 (TTY 1-866-620-2520) to view a copy of the EOC.
- _____ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- _____ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

UNDERSTANDING IMPORTANT RULES

- _____ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- _____ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2023.
- _____ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- _____ For **PPO and HMO-POS** plans - Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services or certain covered services provided by a non-contracted provider, the provider must agree to treat you. Except in an emergency or urgent situations, non-contracted providers may deny care. In addition, you may pay a higher cost for services received by non-contracted providers.
- _____ For **Chronic Conditions Special Needs** plan - This plan is a chronic condition special needs plan (C-SNP). Your ability to enroll will be based on verification that you have a qualifying specific severe or disabling chronic condition.
- _____ For **Platino** plans - This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a State plan under Medicaid.

MULTI-LANGUAGE INTERPRETER SERVICES

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-620-1919 (TTY/TDD 1-866-620-2520). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-620-1919 (TTY/TDD 1-866-620-2520). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务, 帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务, 请致电 1-888-620-1919 (TTY/TDD 1-866-620-2520)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問, 為此我們提供免費的翻譯服務。如需翻譯服務, 請致電 1-888-620-1919 (TTY/TDD 1-866-620-2520)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-620-1919 (TTY/TDD 1-866-620-2520). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-620-1919 (TTY/TDD 1-866-620-2520). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-888-620-1919 (TTY/TDD 1-866-620-2520) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-620-1919 (TTY/TDD 1-866-620-2520). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-620-1919 (TTY/TDD 1-866-620-2520) 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

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MULTI-LANGUAGE INTERPRETER SERVICES

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (1-888-620-1919 (TTY/TDD 1-866-620-2520)). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (1-888-620-1919 (TTY/TDD 1-866-620-2520)). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (1-888-620-1919 (TTY/TDD 1-866-620-2520)) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-620-1919 (TTY/TDD 1-866-620-2520). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-620-1919 (TTY/TDD 1-866-620-2520). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (1-888-620-1919 (TTY/TDD 1-866-620-2520)). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-620-1919 (TTY/TDD 1-866-620-2520) Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-888-620-1919 (TTY/TDD 1-866-620-2520)にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。

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1-888-620-1919
1-866-620-2520
TTY (hearing impaired)

Monday to sunday from 8 a.m. to 8 p.m.

www.sssadvantage.com