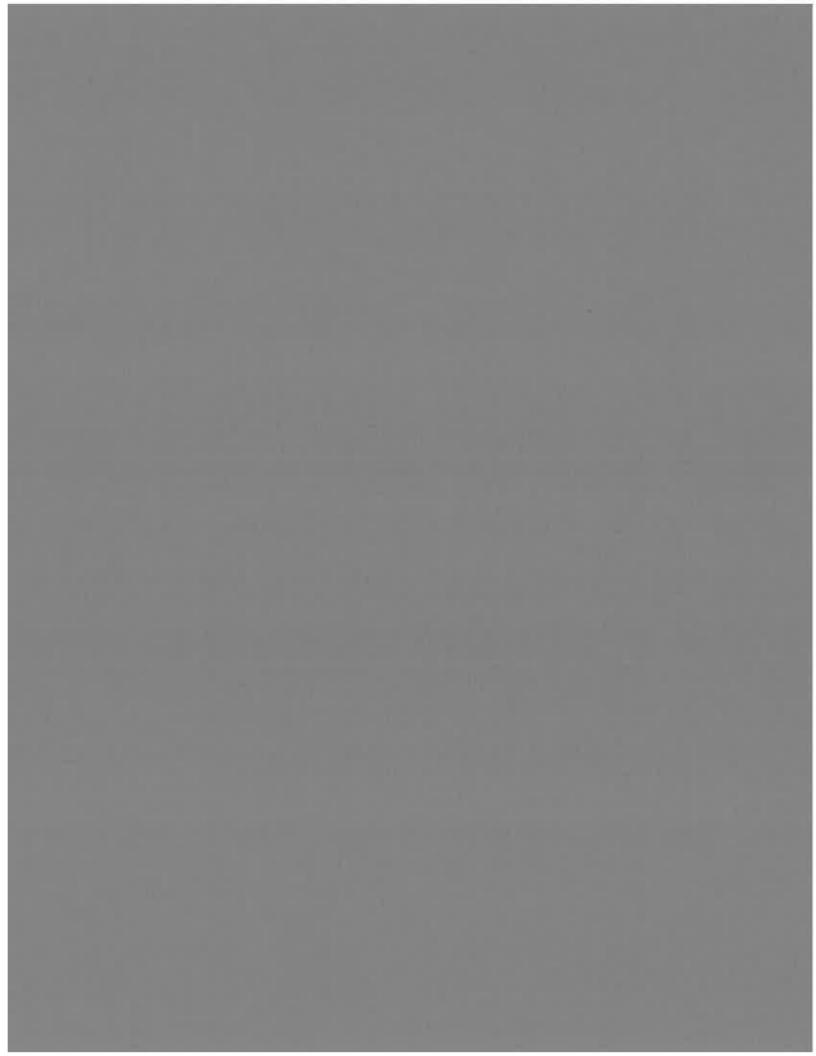
MEDICARE PLATINO 2021

APPENDIX C (1) (21)
MEDICARE ADVANTAGE
PRODUCT PLAN BENEFIT



Appendix C-1

Copy of the Plan Benefit Package (PBP)

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 017, SEGMENT 0.

Module: PBP

Requested By: d3ua

PLAN SYSTEM INFORMATION

Last entry Date: 05/28/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/28/2020 04:37:01 PM SA Western Standard

Time

MA BPT Timestamp: 05/30/2020 04:44:50 PM SA Western Standard

Time

PD BPT Timestamp: 05/30/2020 04:44:51 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/30/2020 04:49:39 PM SA Western Standard

Time

Upload Status: 05/30/2020 #01806

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed

Section B12 Status Completed
Section B13 Status Completed

Section B14 Status Completed
Section B15 Status Completed

Section B16 Status Completed
Section B17 Status Completed
Section B18 Status Completed

Section B19 Status Completed
Section C Status Completed

Section D Status Completed

Section Mrx Status Completed
SECTION A: SECTION A-1





Organization Legal Name: MCS ADVANTAGE, INC. MCS Classicare **Organization Marketing Name:** www.mcsclassicare.com Organization Web Site: MCS Classicare Platino Progreso (HMO D-SNP) Plan Name: Local CCP Organization Type: **HMO** Plan Type: Part A and Part B Enrollee Type: 40010 - Adjuntas, PR Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): Service Area(s): 40050 - Aibonito, PR 40060 - Anasco, PR Service Area(s): 40070 - Arecibo, PR Service Area(s): 40080 - Arroyo, PR Service Area(s): 40090 - Barceloneta, PR Service Area(s): 40100 - Barranquitas, PR Service Area(s): 40110 - Bayamon, PR Service Area(s): 40120 - Cabo Rojo, PR Service Area(s): 40130 - Caguas, PR Service Area(s): 40140 - Camuy, PR Service Area(s): Service Area(s): 40145 - Canovanas, PR 40150 - Carolina, PR Service Area(s): 40160 - Catano, PR Service Area(s): Service Area(s): 40170 - Cayey, PR 40180 - Ceiba, PR Service Area(s): Service Area(s): 40190 - Ciales, PR 40200 - Cidra, PR Service Area(s): 40210 - Coamo, PR Service Area(s): POMINISTRACION 40220 - Comerio, PR Service Area(s): 40230 - Corozal, PR Service Area(s): 40240 - Culebra, PR Service Area(s): Contrato Número -0.040250 - Dorado, PR Service Area(s): 40260 - Fajardo, PR Service Area(s): POSDESP 40265 - Florida, PR Service Area(s): 40270 - Guanica, PR Service Area(s): 40280 - Guayama, PR Service Area(s): 40290 - Guayanilla, PR Service Area(s): 40300 - Guaynabo, PR Service Area(s): 40310 - Gurabo, PR Service Area(s): Service Area(s): 40320 - Hatillo, PR

40330 - Hormigueros, PR

Service Area(s):

Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR





40770 - Yauco, PR Service Area(s):

Contract Number: H5577 017 Plan ID: Segment ID: 0 2021

Puerto Rico Plan Geographic Name:

Is this an Employer-Only plan? No

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for 451029

this plan:

Contract Period:

Does this Plan have a CMS-approved Continuation No

Area?

Do you intend to participate in the PLATINO Yes

program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

Is this D-SNP plan a Medicare zero-dollar cost No

sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all

Medicare premiums and cost sharing for enrollees

in your D-SNP?

SECTION A: SECTION A-3

Yes

Participating Pharmacy Website Address: www.mcsclassicare.com

Formulary Website Address: www.mcsclassicare.com Physician Website Address: www.mcsclassicare.com

Customer Service Contact Phone Number for (866)627-8183

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8183

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Part D Medicare Beneficiaries:

Customer Service Contact TTY/TDD for Current (866)627-8182

Medicare Beneficiaries:





Customer Service Contact Local TTY/TDD for (866)627-8182 Current Medicare Beneficiaries: Customer Service Contact TTY/TDD for (866)627-8182 Prospective Medicare Beneficiaries: Customer Service Contact Local TTY/TDD for (866)627-8182 Prospective Medicare Beneficiaries: Customer Service Contact TTY/TDD for Current (866)627-8182 Part D Medicare Beneficiaries: Customer Service Contact Local TTY/TDD for (866)627-8182 Current Part D Medicare Beneficiaries: Customer Service Contact TTY/TDD for (866)627-8182 Prospective Part D Medicare Beneficiaries: Customer Service Contact Local TTY/TDD for (866)627-8182 Prospective Part D Medicare Beneficiaries: **SECTION A: SECTION A-5** Is your organization filing a standard bid for Section No B of the PBP? Is your organization filing a standard bid for Section No C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for Section No D of the PBP? Do any of your outpatient services have tiered cost No sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software) SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1 Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part C? SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Contrato Número Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee obtains care? POSDE Is there an enrollee Coinsurance? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7 Is there an enrollee Deductible? No No Is there an enrollee Copayment? **SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12** What is your Inpatient Hospital-Acute benefit Original Medicare period? Is authorization required? Yes

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

Yes

Is a referral required for Inpatient Hospital-Acute

Services?

Does the plan provide Inpatient Hospital Psychiatric

Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

No

No

No

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

obtains care?

Is there an enrollee Coinsurance?

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

Original Medicare

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

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

What is your Inpatient Hospital Psychiatric benefit

period?

Is authorization required? Yes

Is a referral required for Inpatient Psychiatric No

Hospital Services?

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

Contrato Núme:

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility No

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay Yes

prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Original Medicare

Is authorization required? Yes
Is a referral required for SNF Services? Yes

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

No

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Yes

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Mandatory

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage amount

for Worldwide Emergency/Urgent Coverage?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

No

No

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

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

Notes: Coverage is managed through reimbursement based

on different fee schedules allowed by our plan, less

Contrato Número

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2 Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Partial Hospitalization? No Notes: Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. **SECTION B: #6 HOME HEALTH SERVICES - BASE 1** Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #6 HOME HEALTH SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #6 HOME HEALTH SERVICES - BASE 3** Is authorization required? Yes Is a referral required for Home Health Services? Yes SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1 Does the plan provide Chiropractic Services as a Yes supplemental benefit under Part C? Select enhanced benefit: : Routine Care Select type of benefit for Routine Care: Mandatory Is this benefit unlimited for Routine Care? No, indicate number Indicate number of visits for Routine Care: 6 Contrato Número Select Routine Care periodicity: Every year Is your Chiropractor Services benefit combined No with either the Acupuncture or Alternative Therapies benefit, or both? Is there a service-specific Maximum Plan Benefit No Coverage amount?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

No

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Deductible? No Is authorization required? Nο Is a referral required for Chiropractic Services? Yes SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 2 Is authorization required? Yes Is a referral required for Occupational Therapy Yes Services? SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BASE 2 Is authorization required? No Is a referral required for Physician Specialist Yes Services? SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? OMINISTRACIO, SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2 Is there an enrollee Coinsurance? No Contrato Número Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Mental Health Specialty No Services - Non-Physician? Notes: Preauthorization required through MCS Solutions. SECTION B: #7F PODIATRY SERVICES - BASE 1 Does the plan provide Podiatry Services as a No supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? **SECTION B: #7F PODIATRY SERVICES - BASE 2** Is there an enrollee Coinsurance? No

No

No

Is there an enrollee Deductible?

Is there an enrollee Copayment?

SECTION B: #7F PODIATRY SERVICES - BASE 3 Is authorization required? No Is a referral required for Podiatrist Services? Yes SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2 Is authorization required? No Is a referral required for Other Health Care Yes **Professional Services?** SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3** Is authorization required? Yes Is a referral required for Psychiatric Services? No Notes: Preauthorization required through MCS Solutions. SECTION B: #7I PT AND SP SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Contrato Número Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2 Is authorization required? Yes Is a referral required for Physical Therapy and Yes Speech-Language Pathology Services? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1 Do you offer an Additional Telehealth benefit for Yes

Part B services?

Select the Medicare-covered benefits that may have

Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual

Sessions for Mental Health Specialty Services: 7h1: Individual Sessions for Psychiatric Services: 14e2:

Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

No



SECTION B: #7.J ADDITIONAL TELEHEALTH SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3 Is authorization required for Additional Telehealth No Services? Is a referral required for Additional Telehealth No Services? SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2 Is authorization required? No Is a referral required for Opioid Treatment Program No Services? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee Coinsurance? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4 Is authorization required? Yes Is a referral required for Outpatient Diagnostic Yes Procedures/Test/Lab Services? SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BAS Is there a service-specific Maximum Enrollee Out-No Contrato Número of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BAS Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Outpatient Yes Diagnostic/Therapeutic Radiological, and X-Ray

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

Services?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

Is authorization required for Medicare-covered Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered No

Observation Services?

Is a referral required for Medicare-covered Yes

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Ambulatory Surgical

Yes

Center Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Services as Yes

a supplemental benefit under Part C?

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

Select type of benefit for Three (3) Pint Deductible Mandatory

Waived:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

No

Contrato Número

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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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a

supplemental benefit under Part C?

Yes

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?

No

Indicate number of trips for Plan Approved Health-

related Location:

32

Select Plan Approved Health-related Location Trips

periodicity:

Every year

Select Type of Transportation for Plan Approved

Health-related Location:

One-way

Select Mode of Transportation for Plan Approved

: Medical Transport

Health-related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Notes: Transportation to Plan-Approved Location provided

by contracted transportation provider, who will

verify remaining trip balance.

SECTION B: #11A DME - BASE 1



Contrato Número



Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #11A DME - BASE 2** Are there preferred vendors/manufacturers for Yes Durable Medical Equipment (DME)? Is authorization required? Yes Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3 Is authorization required? Yes Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 2 Is there an enrollee Copayment? No Do you limit Diabetic Supplies and Services to Yes those from specified manufacturers? Is authorization required? Yes Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. SECTION B: #12 DIALYSIS SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? Nο

SECTION B: #12 DIALYSIS SERVICES - BASE 2

Is authorization required?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

No

Is a referral required for Dialysis Services?

SECTION B: #13A ACUPUNCTURE - BASE 1

Yes

No

No

Does the plan provide Acupuncture as a

supplemental benefit under Part C?

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: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is your Acupuncture benefit combined with either

the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13B OTC ITEMS - BASE 1

Yes

Yes

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Mandatory

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage amount: 75.00

Select Maximum Plan Benefit Coverage Every three months

periodicity:

Does your Maximum Plan Benefit Coverage

amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

No No

No

SECTION B: #13B OTC ITEMS - BASE 2

No

Is there an enrollee Coinsurance?

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?





SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive Services

Attestation

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

Is authorization required? No Is a referral required? No

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

No

Yes

Does the plan provide the Annual Physical Exam as

a supplemental benefit under Part C?

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

Does the plan provide Other Defined Supplemental

Benefits as a benefit under Part C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education: 14c2: Nutritional/Dietary

> Benefit: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline)*: 14c17: Alternative Therapies*: 14c18: Therapeutic

Massage* Mandatory

Mandatory

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

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

Individual Sessions

No, indicate number

Mandatory

6

: Physical Fitness

Mandatory

: Web/Phone-based technologies: Nursing Hotline

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

6

Select type of benefit for Alternative Therapies:

No, indicate number Is this benefit unlimited for Alternative Therapies?

Indicate number of visits offered for Alternative

Therapies:

Mandatory



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Contrato Número

Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

Select type of benefit for Therapeutic Massage:

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

No

No

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

No

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

No

No

Is authorization required? Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes: Route to Wellness - Health and preventive

workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta -Guidance on preventive measures and actions to take in case of natural disasters and to reduce health

complications.

Nutritional/Dietary Benefit Notes:

Fitness Benefit Notes:*

Contrato Número 21 - 00POSDE

Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.

Route to Wellness - Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.

MCS MedilAnea- Nursing Hotline. Remote Access Technologies (Nursing Hotline)

Notes:

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

Alternative Therapies Notes:* Foot reflexology is limited to six (6) visits per year

and must be ordered by a physician or medical professional.



Therapeutic Massage Notes:*

Therapeutic massage is limited to six (6) visits per year and must be ordered by a physician or medical

professional.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Nο

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

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

Services?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

No

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

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?

Is authorization required for Other Medicare-No

covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is Authorization Required? Yes Does the plan offer step therapy? Yes

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





SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?

No

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

No

Yes

Does the plan provide Preventive Dental Items as a

supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits:

E W H - d To

: Non-routine Services: Diagnostic Services:

Restorative Services: Endodontics: Periodontics:

Extractions: Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services

Mandatory Select type of benefit for Non-routine Services:

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:

Select the Diagnostic Services periodicity: Every six months

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:

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

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

Indicate Maximum Plan Benefit Coverage amount:

3000.00

Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No





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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

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

Services?

Notes: Coverage for crowns included under "Other

> Services". The replacement of a removable dental prosthesis will be covered five years after its initial insertion. The member who does not comply with the stated five-year term from the initial insertion, may use the Maximum Plan Benefit Coverage amount for services related to his/her removable

> > OMINISTRACION

Contrato Número

prosthesis.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Yes

Select enhanced benefit: : Routine Eye Exams

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:

Every year

Select the Routine Eye Exams periodicity:

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental

Yes

benefit under Part C?

Select enhanced benefits: : Contact lenses: Eyeglasses (lenses and frames):

Eyeglass lenses: Eyeglass frames

Select type of benefit for Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses?

Yes

Select type of benefit for Eyeglasses (lenses and

Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

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

SECTION B: #17B EYEWEAR - BASE 3

Yes

Is there a service-specific Maximum Plan Benefit

Select the Maximum Plan Benefit Coverage type:

Coverage amount?

Plan-specified amount per period

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Is there an enrollee Coinsurance?

Yes

Indicate Combined Maximum Plan Benefit

Coverage amount:

1000.00

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Every year

SECTION B: #17B EYEWEAR - BASE 4

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for Eyewear? No

Notes: Eyewear benefit maximum amount includes repair

of eyewear. Provider and/or member must verify remaining combined maximum plan benefit

coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Yes

1

Select enhanced benefits:

: Routine Hearing Exams: Fitting/Evaluation for

Contrato Número

Hearing Aid

Select type of benefit for Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

Exams?

Every year

Mandatory

No, indicate num (EMINISTRACIO)

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number



Indicate number for Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION	B: #18A HEARING EXAMS -	BASE 2
		CONTRACTOR OF THE PARTY OF THE

1

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there an enrollee Deductible?

No

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

Yes

Select enhanced benefits:

: Hearing Aids (all types)

Select type of benefit for Hearing Aids (all types):

Is this benefit unlimited for Hearing Aids (all

No, indicate number

types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity:

Every year

Mandatory

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Does the Maximum Plan Benefit Coverage Amount

Both ears combined

apply per ear or for 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

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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





Notes:

Benefit and Maximum Plan Coverage Amount

includes benefit for repair of devices.

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

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

No

Do you offer Special Supplemental Benefits for the

Yes

Chronically Ill?

Select what type of benefit your SSBCI includes:

: Additional Benefits

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

Does your VBID/MA Uniformity Flexibility/SSBCI

benefit offer additional Part C benefits?

Yes

1

How many packages do your Additional Benefits

w many packages do your Additional Benefits

contain? (1-15)

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

#1

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

Is there a prerequisite for any additional benefits for

No

this package?

Select all the Non-Medicare-covered additional

: 13i: Non-Primarily Health Related Benefits for the

benefits offered in this package:

Chronically Ill

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement? No
Is there a maximum benefit amount? Yes
Specify the maximum benefit amount: 125.00

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

Notes:

)

Contrato Número

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The following SSBCI benefits will be offered: Food and Produce - Subsidy for Groceries - Pest
Control - Transportation for Non-Medical Needs General Supports for Living: (1) Home Assistance
Services (2) Subsidy for Electricity, Water, Phone,
Internet, Gas Maximum benefit coverage
periodicity is every three months. Maximum benefit
amount is for the combination of two benefits,
"Food and Produce" and "Subsidy for Electricity,
Water, Phone, Internet, Gas". Amount does not roll
over/accumulate from one period to the next.
Maximum benefit amount does not apply to "Home
Assistance Services".

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce: Pest Control: Transportation for Non-Medical Needs: General Supports for

Living

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

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?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

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

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: Food and Produce is a subsidy for groceries.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Cost? SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1RAC/O/

Is there an enrollee Coinsurance? Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACK

Notes: Services listed in this category will be combined

with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following

Contrato Número

options: - Pest Control - Preventive home

cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General

Supports for Living")

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

Yes

Does the plan provide Transportation for Non-

Medical Needs as a supplemental benefit under Part

C?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Location:

Mandatory

Is this benefit unlimited for number of trips for

No

0

Plan-approved Location?

Indicate number of trips for Plan-approved

Location:

Select Plan-approved Location Trips periodicity:

Every year

Select Type of Transportation for Non-Medical

One-way

Needs for Plan-approved Location:

Select Mode of Transportation for Non-Medical

: Medical Transport: Other, Describe

Need for Plan-approved Location:

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment? No
Is authorization required? No

Is a referral required for Transportation for Non-

Medical Needs?

No

Notes:

Fleet includes 4-door sedans, minivans, buses with hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i - Transportation for Non-Medical Needs, if the

Contrato Número

beneficiary qualifies for SSBCI.

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

Yes

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Mandatory

Select type of benefit for General Supports for

Living:

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No



SECTION B: VBID/UF/SSBCI 19B #13I GENE	RAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1
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
SECTION B: VBID/UF/SSBCI 19B #13I GENE	RAL SUPPORTS FOR LIVING - BASE 3: PACKAGE
Notes:	General Supports for Living contains two separate benefits: (1) Home Assistance - Eight (8) visits per year (two per quarter) for Home Assistance (Plumbing, Electricity, Locksmith) and categories listed under Pest Control. (2) Subsidy for Electricity/Water/Telephone/Internet/Gas
SECTION C: Y	V/T - GENERAL - US
Do you offer a US Visitor/Travel Program?	No
	EDUCTIBLE (IN-NETWORK)
Is there an In-Network Plan Deductible?	No
SECTION D: MAX ENROLI	LEE COST LIMIT (IN-NETWORK)
Is there an In-Network Maximum Enrollee Out-of-Pocket Cost?	Yes
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Cost at the Voluntary or Mandatory Level?	Voluntary
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00
Select the benefits that apply to the In-Network Maximum Enrollee Out-of-Pocket cost:	: In-Network Medicare-covered benefits Yes
Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?	2 1 - 0 0
SECTION D: MAX P	LAN BENEFIT COVERAGE
Is there a Maximum Plan Benefit Coverage Amount?	No No DE SAY
SECTION D: REDUCTION	S IN COST SHARING - GENERAL
Do you offer Reductions in Cost Sharing?	No
SECTION D: COMBI	NED BENEFITS - GENERAL
Do you offer Combined Supplemental Benefits with uniform cost sharing?	n No
SECTION RX: ME	DICARE RX GENERAL 1
Does your plan offer a Medicare Prescription drug (Part D) benefit?	Yes
Select the type of drug benefit:	Defined Standard

Describe the components of your pharmacy network (select all that apply):

Sponsor attests that it will comply with 42 CFR 423,154.

: Standard Retail: Out-of-Network: Standard Mail-

Order: Long-Term Care

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

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? No Does plan utilize ceiling pricing? No Are there quantity limits on certain prescription Yes drugs?

Is prior authorization required for certain

prescription drugs?

Will your plan be limiting on-formulary coverage of drugs to certain indications (i.e., are you

implementing indication-based formulary design)?

Do any drugs in your formulary require a step therapy plan?

Do you pay for over-the-counter medications

(OTCs) under the utilization management program?

No

Yes

Yes

No

30

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply: Standard Retail Cost Sharing - 2 month Supply: Location/supply amount(s) that apply: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost 60

Sharing 2-month supply:

Enter number of days for Standard Retail Cost 90

Sharing 3-month supply:

Select all Out-of-Network Pharmacy : Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network 30

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 3-month supply

Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order Cost

Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month

Location/supply amount(s) that apply: Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill? : Long-Term Care Pharmacy - 1-month supply

No

90

Yes

SECTION RX: MEDICARE RX - NOTE





Notes: The PBP will implement a Part D RI program in

accordance with any final Application Proposal

approved by CMMI.

DATA REPORT FOR Contract H5577, PLAN 002, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

Last entry Date: 05/27/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/27/2020 05:38:20 PM SA Western Standard

Time

MA BPT Timestamp: 05/30/2020 04:44:40 PM SA Western Standard

Time

PD BPT Timestamp: 05/30/2020 04:44:41 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/30/2020 04:49:39 PM SA Western Standard

Time

Completed

Upload Status: 05/30/2020 #01806

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Completed Section B8 Status Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed

Section B15 Status

Section B16 Status

Completed
Section B17 Status

Completed
Section B18 Status

Completed
Section B19 Status

Completed
Section C Status

Completed
Section D Status

Completed

Section Mrx Status



SECTION A: SECTION A-1

SECTION A:	SECTION A-1
Organization Legal Name:	MCS ADVANTAGE, INC.
Organization Marketing Name:	MCS Classicare
Organization Web Site:	www.mcsclassicare.com
Plan Name:	MCS Classicare Platino Ideal (HMO D-SNP)
Organization Type:	Local CCP
Plan Type:	НМО
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
Service Area(s):	40020 - Aguada, PR
Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR
Service Area(s):	40230 - Corozal, PR Contrato Número
Service Area(s):	40240 - Culebra, PR (2 1 - 0 0 3)
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR





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

40330 - Hormigueros, PR
40340 - Humacao, PR
40350 - Isabela, PR
40360 - Jayuya, PR
40370 - Juana Diaz, PR
40380 - Juncos, PR
40390 - Lajas, PR
40400 - Lares, PR
40410 - Las Marias, PR
40420 - Las Piedras, PR
40430 - Loiza, PR
40440 - Luquillo, PR
40450 - Manati, PR
40460 - Maricao, PR
40470 - Maunabo, PR
40480 - Mayaguez, PR
40490 - Moca, PR
40500 - Morovis, PR
40510 - Naguabo, PR
40520 - Naranjito, PR
40530 - Orocovis, PR
40540 - Patillas, PR
40550 - Penuelas, PR
40560 - Ponce, PR
40570 - Quebradillas, PR
40580 - Rincon, PR
40590 - Rio Grande, PR
40610 - Sabana Grande, PR
40620 - Salinas, PR
40630 - San German, PR
40640 - San Juan, PR
40650 - San Lorenzo, PR
40660 - San Sebastian, PR
40670 - Santa Isabel, PR

40680 - Toa Alta, PR 40690 - Toa Baja, PR 40700 - Trujillo Alto, PR

40710 - Utuado, PR 40720 - Vega Alta, PR 40730 - Vega Baja, PR 40740 - Vieques, PR 40750 - Villalba, PR





Service Area(s): 40760 - Yabucoa, PR Service Area(s): 40770 - Yauco, PR

Contract Number: H5577
Plan ID: 002
Segment ID: 0
Contract Period: 2021

Plan Geographic Name: Puerto Rico

Is this an Employer-Only plan?

SECTION A: SECTION A-2

Indicate CY2021 total projected member months for 419830

this plan:

Does this Plan have a CMS-approved Continuation No

Area?

Do you intend to participate in the PLATINO Yes

program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

Is this D-SNP plan a Medicare zero-dollar cost

sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all

Medicare premiums and cost sharing for enrollees

in your D-SNP?

SECTION A: SECTION A-3

No

Yes

Participating Pharmacy Website Address: www.mcsclassicare.com
Formulary Website Address: www.mcsclassicare.com
Physician Website Address: www.mcsclassicare.com

Customer Service Contact Phone Number for (866)627-8183

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8183

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for

Prospective Part D Medicare Beneficiaries:

(787)620-2528





Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182
SECTION A:	SECTION A-5
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION A:	SECTION A-6
Is your organization filing a standard bid for Section D of the PBP?	No
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No
SECTION B: #1A INPATIENT	Γ HOSPITAL-ACUTE - BASE 1
Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?	No
SECTION B: #1A INPATIENT	T HOSPITAL-ACUTE - BASE 2
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No ROMAN CONTRACTOR OF CONTRAC
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No Contrato Número
Is there an enrollee Coinsurance?	No POSDESA
	Γ HOSPITAL-ACUTE - BASE 7
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
	HOSPITAL-ACUTE - BASE 12
What is your Inpatient Hospital-Acute benefit period?	Original Medicare
In anth animation magning 49	Voc

Yes

Is authorization required?

Is a referral required for Inpatient Hospital-Acute

Services?

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

Yes

Does the plan provide Inpatient Hospital Psychiatric No

Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

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

No

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance?

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

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

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

What is your Inpatient Hospital Psychiatric benefit

period?

*

Original Medicare

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

Hospital Services?

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

No

Yes

No

No

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay

prior to SNF admission?

Indicate the Number of Hospital Days Required Zero

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Original Medicare

Is authorization required? Yes
Is a referral required for SNF Services? Yes

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







Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C? No

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes
Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment? No

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

Does the plan provide Worldwide Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Mandatory

Mandatory

No

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Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent

Coverage:

Is there a Maximum Plan Benefit Coverage amount

for Worldwide Emergency/Urgent Coverage?

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

ost?

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

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

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

Preauthorization required through MCS Solutions, Notes:

except for Emergency and Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Home Health Services? Yes

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

: Routine Care Select enhanced benefit:

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: 6

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

No

No







Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

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

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

Yes

Is there a service-specific Maximum Enrollee Out-No

Is a referral required for Chiropractic Services?

of-Pocket Cost?

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

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

Is authorization required? Yes Is a referral required for Occupational Therapy Yes

Services?

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

Contrato Número

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

Is there an enrollee Coinsurance?

No Is there an enrollee Deductible? No No

Is there an enrollee Copayment? SECTION B: #7D PHYSICIAN SPECIALIST SERVICES - BA

Is authorization required? No Is a referral required for Physician Specialist Yes

Services?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

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

Yes Is authorization required? Is a referral required for Mental Health Specialty No

Services - Non-Physician?

Preauthorization required through MCS Solutions. Notes:

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

No

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

Is authorization required? No Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

Notes: Preauthorization required through MCS Solutions.

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

Is authorization required? Yes Is a referral required for Physical Therapy and Yes

Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit for Yes

Part B services?





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

: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1 Individual Sessions for Psychiatric Services: 14e2:

Contra

Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

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

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

No

No

No

Is authorization required for Additional Telehealth

Services?

Services?

Is a referral required for Additional Telehealth

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

Is there an enrollee Coinsurance?

No Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - B.

Is authorization required? No No

Is a referral required for Opioid Treatment Program Services?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? Yes Is a referral required for Outpatient Diagnostic Yes

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required?

Yes

Is a referral required for Outpatient

Yes

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered

No

Observation Services?

Is a referral required for Medicare-covered

Yes

Outpatient Hospital Services?

Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Ambulatory Surgical

Yes

Center Services?

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

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Outpatient Substance

No

Abuse?

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

Does the plan provide Outpatient Blood 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:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Mandatory

Is there an enrollee Coinsurance? No

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

Is there an enrollee Deductible? No No Is there an enrollee Copayment? Is authorization required? No Is a referral required for Outpatient Blood Services? No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a Yes

supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?

Indicate number of trips for Plan Approved Health-

related Location:

20

No

Select Plan Approved Health-related Location Trips

periodicity:

Every year

Select Type of Transportation for Plan Approved

Health-related Location:

One-way

Select Mode of Transportation for Plan Approved

Health-related Location:

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment?

No

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

Transportation to Plan-Approved Location provided Notes:

by contracted transportation provider, who will

verify remaining trip balance.

SECTION B: #11A DME - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

SECTION B: #11A DME - BASE 2

Yes

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Is authorization required? Yes

Pre-authorization by PCP (for corresponding Notes:

> services) is managed through Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

No

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

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

Is authorization required?

Pre-authorization by PCP (for corresponding Notes:

> services) is managed through Referral/Authorization Form.

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

Is there an enrollee Copayment? No Yes

Do you limit Diabetic Supplies and Services to

those from specified manufacturers?

Is authorization required? Yes

Pre-authorization by PCP (for corresponding Notes:

> services) is managed through Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Yes

Does the plan provide Acupuncture as a

supplemental benefit under Part C?

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: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

No

No

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

SECTION B: #13B OTC ITEMS - BASE 1

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

50.00

Indicate Maximum Plan Benefit Coverage amount:

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?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

No

No

No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

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?

SECTION B: #13C MEAL BENEFIT - BASE 1

No

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.

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

Medicare-covered Zero Dollar Preventive Services

Attestation

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

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical Exam as

a supplemental benefit under Part C?

No

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

Does the plan provide Other Defined Supplemental

Benefits as a benefit under Part C?

Select enhanced benefit (Select all that apply):

Yes

: 14c1: Health Education: 14c2: Nutritional/Dietary

Benefit: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*: 14c17: Alternative Therapies*: 14c18: Therapeutic

Massage*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary

Mandatory

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline): No, indicate number

6

Individual Sessions

Mandatory

: Physical Fitness

Mandatory



Select the type of Remote Access Technologies

: Web/Phone-based technologies: Nursing Hotline

offered (Select all that apply):

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

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:

Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

Select type of benefit for Therapeutic Massage: Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

No

No

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

No

No

Is authorization required?

Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes:

Route to Wellness - Health and preventive workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta - Guidance on preventive measures and actions to take in case of natural disasters and to reduce health complications.

Nutritional/Dietary Benefit Notes:

Complications.

Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.

Fitness Benefit Notes:* Route to Wellness - Exercise and Nutrition

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Education Interventions. Member has access to fitness classes to promote physical activity and a

healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physical

to treat the most common conditions, such as

allergies, flu, among others.

Remote Access Technologies (Nursing Hotline)

Notes:

MCS MedilÂnea- Nursing Hotline.

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

Alternative Therapies Notes:* Foot reflexology is limited to six (6) visits per year

and must be ordered by a physician or medical

professional.

Therapeutic Massage Notes:*

Therapeutic massage is limited to six (6) visits per

year and must be ordered by a physician or medical

professional.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Is authorization required?

Is a referral required for Kidney Disease Education No

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

Is there an enrollee Copayment? No

Is authorization required for Medicare-covered

Glaucoma Screening?

No

No

Is authorization required for Medicare-covered Diabetes Self-Management Training?

Is authorization required for Medicare-covered N

Barium Enemas?

No

Is authorization required for Medicare-covered

No

Digital Rectal Exams?

Is authorization required for Medicare-covered N

EKG following Welcome Visit?

No

Is authorization required for Other Medicare-

No

covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

No

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





Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs No

as part of a bundled service as a mandatory

supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a No

supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items Yes

as a supplemental benefit under Part C?

Select enhanced benefits: : Non-routine Services: Diagnostic Services:

Restorative Services: Endodontics: Periodontics:

Extractions: Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine 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: Every six months

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:

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics:

Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics:

Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes



Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:

2500.00

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Yes

Select which Comprehensive Dental Services have

: Prosthodontics, Other Oral/Maxillofacial Surgery,

a Coinsurance (Select all that apply):

Other Services

Indicate Minimum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

0%

Indicate Maximum Coinsurance percentage for

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services:

20%

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

Notes: Coverage for crowns included under "Other

Services". Minimum coinsurance applies to Oral

Surgery. Maximum coinsurance applies to

Prosthodontics and crowns. The replacement of a removable dental prosthesis will be covered five years after its initial insertion. The member who does not comply with the stated five-year term from the initial insertion, may use the Maximum Plan

Benefit Coverage amount for services related to

his/her removable prosthesis.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Yes

Select enhanced benefit:

: Routine Eye Exams

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

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?



Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

No

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

Is there an enrollee Deductible?

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No
Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

Yes

Does the plan provide Eyewear as a supplemental

benefit under Part C?

Select enhanced benefits:

: Contact lenses: Eyeglasses (lenses and frames):

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Eyeglass lenses: Eyeglass frames

Select type of benefit for Contact lenses: Mandatory

Is this benefit unlimited for Contact lenses? Yes

Select type of benefit for Eyeglasses (lenses and Mandatory

frames):

Is this benefit unlimited for Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

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

SECTION B: #17B EYEWEAR - BASE 3

Yes

Yes

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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?

Indicate Combined Maximum Plan Benefit 400.00

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?

Is a referral required for Eyewear?

Notes: Eyewear benefit maximum amount includes repair

of eyewear. Provider and/or member must verify remaining combined maximum plan benefit

coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

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

No, indicate number

Exams?

Indicate number for Routine Hearing Exams: 1

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

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Select Fitting/Evaluation for Hearing Aid

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for Hearing

Aid:

Every year

1

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit No

·Coverage amount?

Is there an enrollee Deductible? No
Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

Is there an enrollee Copayment?

Is authorization required?

No

Is a referral required for Hearing Exams?

No

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

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

No, indicate number

types)?

Indicate quantity for Hearing Aids (all types): 2

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

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Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

2000.00 Indicate Maximum Plan Benefit Coverage amount: Indicate Maximum Plan Benefit Coverage Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Yes

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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

Benefit and Maximum Plan Coverage Amount Notes:

includes benefit for repair of devices.

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

Does your plan include MA Uniformity Flexibility

with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the

Chronically Ill?

No Yes

: Additional Benefits

Select what type of benefit your SSBCI includes:

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

Does your VBID/MA Uniformity Flexibility/SSBCI

benefit offer additional Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

Yes

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

1

#1

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

No

Is there a prerequisite for any additional benefits for

Select all the Non-Medicare-covered additional

this package?

: 13i: Non-Primarily Health Related Benefits for the

benefits offered in this package:

Chronically Ill

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

Are any benefits exempt from the plan-level

No

deductible?



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

Are you offering retroactive reimbursement?

No

Is there a maximum benefit amount?

Yes

Specify the maximum benefit amount:

160.00

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

The following SSBCI benefits will be offered: -Notes:

Food and Produce - Subsidy for Groceries - Pest Control - Transportation for Non-Medical Needs -General Supports for Living: (1) Home Assistance Services (2) Subsidy for Electricity, Water, Phone,

Internet, Gas Maximum benefit coverage

periodicity is every three months. Maximum benefit amount is for the combination of two benefits, "Food and Produce" and "Subsidy for Electricity, Water, Phone, Internet, Gas". Amount does not roll over/accumulate from one period to the next.

Maximum benefit amount does not apply to "Home

Assistance Services".

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce: Pest Control: Transportation for Non-Medical Needs: General Supports for

Living

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

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Nο

Select type of benefit for Food and Produce:

Mandatory

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

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

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: Food and Produce is a subsidy for groceries.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a

Select type of benefit for Pest Control:

supplemental benefit under Part C?

Mandatory

Is there a service-specific Maximum Plan Benefit

No

Yes

Coverage amount?





Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

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 Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Services listed in this category will be combined Notes:

with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following

options: - Pest Control - Preventive home

cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General

Supports for Living")

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

Yes

Does the plan provide Transportation for Non-

Medical Needs as a supplemental benefit under Part

 \mathbb{C} ?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Location: Mandatory

Is this benefit unlimited for number of trips for No

Plan-approved Location?

Indicate number of trips for Plan-approved 0

Location:

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

Needs for Plan-approved Location:

Select Mode of Transportation for Non-Medical

Need for Plan-approved Location:

: Medical Transport: Other, Describe

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

No

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment? No

Is authorization required? No



Is a referral required for Transportation for Non-

Medical Needs?

Notes:

Fleet includes 4-door sedans, minivans, buses with hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i -Transportation for Non-Medical Needs, if the

beneficiary qualifies for SSBCI.

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

No

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Mandatory

Living:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

Yes

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

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 No

Living?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

General Supports for Living contains two separate Notes:

benefits: (1) Home Assistance - Eight (8) visits per

year (two per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith) and categories

listed under Pest Control. (2) Subsidy for Electricity/Water/Telephone/Internet/Gas

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible?

No

Yes

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

Is there an In-Network Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Voluntary

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

3400.00

Pocket Cost Amount:





Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicare-

covered plan services?

: In-Network Medicare-covered benefits

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with

uniform cost sharing?

No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Yes

Select the type of drug benefit:

Defined Standard

Describe the components of your pharmacy network

(select all that apply):

: Standard Retail: Out-of-Network: Standard Mail-

Order: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR

423,154.

SECTION RX: MEDICARE RX GENERAL 2

No

No

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

Yes Yes

Is prior authorization required for certain

prescription drugs?

Will your plan be limiting on-formulary coverage of

drugs to certain indications (i.e., are you

implementing indication-based formulary design)?

Do any drugs in your formulary require a step

therapy plan?

No

Do you pay for over-the-counter medications

(OTCs) under the utilization management program?

Yes

No

30

90

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

Location/supply amount(s) that apply:

: Standard Retail Cost Sharing - 1 month Supply: Standard Retail Cost Sharing - 2 month Supply:

Contrato Número

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Standard Retail Cost Sharing - 3 month Supply



60





Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

: Out-of-Network Pharmacy - one month supply

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

: Standard Mail-Order - 3-month supply

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order Cost

Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month

Location/supply amount(s) that apply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill? : Long-Term Care Pharmacy - 1-month supply

No

Yes

30

90

SECTION RX: MEDICARE RX - NOTES

Notes: The PBP will implement a Part D RI program in

accordance with any final Application Proposal

approved by CMMI.

DATA REPORT FOR Contract H5577, PLAN 028, SEGMENT 0

Module: **PBP**

Requested By: d3ua

PLAN SYSTEM INFORMATION Last entry Date: 05/27/2020

PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/27/2020 05:44:07 PM SA Western Standard

Time

MA BPT Timestamp: 05/30/2020 04:44:52 PM SA Western Standard

Time

PD BPT Timestamp: 05/30/2020 04:44:53 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/30/2020 04:49:39 PM SA Western Standard

Time

Upload Status: 05/30/2020 #01806

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed

Section B2 Status Completed

Section B3 Status Completed Section B4 Status Completed

Section B5 Status Completed

Section B6 Status Completed





Completed Section B7 Status Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed Section C Status Completed Section D Status Completed Section Mrx Status Completed

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Organization Web Site: www.mcsclassicare.com

Plan Name: MCS Classicare Platino ClÃ;sico (HMO D-SNP)

Organization Type: Local CCP

Plan Type: HMO

Enrollee Type: Part A and Part B

Service Area(s): 40010 - Adjuntas, PR

Service Area(s): 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR

Service Area(s): 40040 - Aguas Buenas, PR

Service Area(s): 40050 - Aibonito, PR

Service Area(s): 40060 - Anasco, PR

Service Area(s): 40070 - Arecibo, PR

Service Area(s): 40080 - Arroyo, PR

Service Area(s): 40090 - Barceloneta, PR

Service Area(s): 40100 - Barranquitas, PR

Service Area(s): 40110 - Bayamon, PR

Service Area(s): 40120 - Cabo Rojo, PR

Service Area(s): 40130 - Caguas, PR

Service Area(s): 40140 - Camuy, PR

Service Area(s): 40145 - Canovanas, PR Service Area(s): 40150 - Carolina, PR

Service Area(s): 40150 - Carolina, Pl Service Area(s): 40160 - Catano, PR

Service Area(s): 40170 - Cayey, PR





Service Area(s):	40180 - Ceiba, PR	
Service Area(s):	40190 - Ciales, PR	
Service Area(s):	40200 - Cidra, PR	
Service Area(s):	40210 - Coamo, PR	
Service Area(s):	40220 - Comerio, PR	
Service Area(s):	40230 - Corozal, PR	
Service Area(s):	40240 - Culebra, PR	
Service Area(s):	40250 - Dorado, PR	
Service Area(s):	40260 - Fajardo, PR	
Service Area(s):	40265 - Florida, PR	
Service Area(s):	40270 - Guanica, PR	
Service Area(s):	40280 - Guayama, PR	
Service Area(s):	40290 - Guayanilla, PR	
Service Area(s):	40300 - Guaynabo, PR	
Service Area(s):	40310 - Gurabo, PR	
Service Area(s):	40320 - Hatillo, PR	
Service Area(s):	40330 - Hormigueros, PR	
Service Area(s):	40340 - Humacao, PR	
Service Area(s):	40350 - Isabela, PR	
Service Area(s):	40360 - Jayuya, PR	
Service Area(s):	40370 - Juana Diaz, PR	
Service Area(s):	40380 - Juncos, PR	
Service Area(s):	40390 - Lajas, PR	
Service Area(s):	40400 - Lares, PR	
Service Area(s):	40410 - Las Marias, PR	
Service Area(s):	40420 - Las Piedras, PR	
Service Area(s):	40430 - Loiza, PR	
Service Area(s):	40440 - Luquillo, PR	
Service Area(s):	40450 - Manati, PR	
Service Area(s):	40460 - Maricao, PR	
Service Area(s):	40470 - Maunabo, PR	
Service Area(s):	40480 - Mayaguez, PR	
Service Area(s):	40490 - Moca, PR	
Service Area(s):	40500 - Morovis, PR	
Service Area(s):	40510 - Naguabo, PR	
Service Area(s):	40520 - Naranjito, PR	
Service Area(s):	40530 - Orocovis, PR	
Service Area(s):	40540 - Patillas, PR	
Service Area(s):	40550 - Penuelas, PR	
Service Area(s):	40560 - Ponce, PR	
Service Area(s):	40570 - Quebradillas, PR	
Service Area(s):	40580 - Rincon, PR	





40590 - Rio Grande, PR Service Area(s): 40610 - Sabana Grande, PR Service Area(s): Service Area(s): 40620 - Salinas, PR Service Area(s): 40630 - San German, PR Service Area(s): 40640 - San Juan, PR Service Area(s): 40650 - San Lorenzo, PR 40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR Service Area(s): 40720 - Vega Alta, PR Service Area(s): 40730 - Vega Baja, PR Service Area(s): 40740 - Viegues, PR Service Area(s): 40750 - Villalba, PR Service Area(s): 40760 - Yabucoa, PR Service Area(s): 40770 - Yauco, PR Service Area(s): Contract Number: H5577 028 Plan ID: Segment ID: 0 2021 Contract Period: Puerto Rico Plan Geographic Name:

SECTION A: SECTION A-2

No

No

Yes

Yes

No

Dual-Eligible

139138

Indicate CY2021 total projected member months for

this plan:

Does this Plan have a CMS-approved Continuation

Area?

Do you intend to participate in the PLATINO

program?

Is this a Special Needs Plan?

Is this an Employer-Only plan?

Special Needs Plan Type:

Is this D-SNP plan a Medicare zero-dollar cost

sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all

Medicare premiums and cost sharing for enrollees

in your D-SNP?

Yes

SECTION A: SECTION A-3

Participating Pharmacy Website Address: www.mcsclassicare.com Formulary Website Address: www.mcsclassicare.com Physician Website Address: www.mcsclassicare.com







Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)627-8183
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2530
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)627-8181
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2528
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)627-8183
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2530
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181
SECTION AS	SECTION A-4
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182
SECTION A	SECTION A-5
Is your organization filing a standard bid for Section B of the PBP?	No
Is your organization filing a standard bid for Section C of the PBP?	No
SECTION AS	SECTION A-6 No
Is your organization filing a standard bid for Section D of the PBP?	No Contrate Número

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section No
D of the PBP?

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)





Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

No

No

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

obtains care?

Is there an enrollee Coinsurance? No

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

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

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

What is your Inpatient Hospital-Acute benefit Original Medicare

period?

Yes Is authorization required? Is a referral required for Inpatient Hospital-Acute Yes

Services?

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

Does the plan provide Inpatient Hospital Psychiatric No

Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost No

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

Is there an enrollee Coinsurance?

No

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

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

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

What is your Inpatient Hospital Psychiatric benefit Original Medicare

period?

Is authorization required? Yes

Is a referral required for Inpatient Psychiatric No

Hospital Services?

Preauthorization required through MCS Solutions, Notes:

Yes

except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility No

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay

prior to SNF admission?

Indicate the Number of Hospital Days Required Zero Prior to SNF Admission (0-2): Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? **SECTION B: #2 SNF - BASE 2** Does this plan's Medicare-covered benefit cost No sharing vary by the Skilled Nursing Facility in which an enrollee obtains care? Is there an enrollee Coinsurance? No SECTION B: #2 SNF - BASE 6 Is there an enrollee Copayment? No **SECTION B: #2 SNF - BASE 10** What is your SNF benefit period? Original Medicare Yes Is authorization required? Yes Is a referral required for SNF Services? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 1 Does the plan provide Cardiac and Pulmonary No Rehabilitation Services as a supplemental benefit under Part C? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3 Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 4 Is authorization required? Yes Is a referral required for Cardiac and Pulmonary No Rehabilitation Services? SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2 No Is there an enrollee Copayment? SECTION B: #4B URGENTLY NEEDED SERVICES Is there a service-specific Maximum Enrollee Out-No Contrato Número of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #4B URGENTLY NEEDED SERVICE Is there an enrollee Copayment? No SECTION B: #4C WORLDWIDE EMERGENCY/URGENT COVERAGE - BASE 1

Does the plan provide Worldwide

Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit:

: Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage amount

for Worldwide Emergency/Urgent Coverage?

No

Is there a service-specific Maximum Enrollee Out-

CD 1 4 C 429

No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

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

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

No No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment?

Is authorization required?

Yes

Is a referral required for Partial Hospitalization?

No

Is a referral required for Partial Hospitalization?

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Home Health Services? Yes

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?





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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Yes

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

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

No, indicate number Is this benefit unlimited for Routine Care?

Indicate number of visits for Routine Care: 6

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

No

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is authorization required? No Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

Is authorization required? Yes Is a referral required for Occupational Therapy

Yes

Services?

SECTION B: #7D PHYSICIAN SPECIALIST SERVICE

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

SECTION B: #7D PHYSICIAN SPECIALIST

Is authorization required? No

Is a referral required for Physician Specialist Yes

Services?





SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3 Is authorization required? Yes No Is a referral required for Mental Health Specialty Services - Non-Physician? Preauthorization required through MCS Solutions. Notes: **SECTION B: #7F PODIATRY SERVICES - BASE 1** Does the plan provide Podiatry Services as a No supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #7F PODIATRY SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? **SECTION B: #7F PODIATRY SERVICES - BASE 3** Is authorization required? No Is a referral required for Podiatrist Services? Yes SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Contrato Número Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2 Is authorization required? No Is a referral required for Other Health Care Yes **Professional Services? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1** Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required?

Yes

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



Preauthorization required through MCS Solutions. Notes: SECTION B: #7I PT AND SP SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost?

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

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

Is authorization required? Yes Is a referral required for Physical Therapy and Yes Speech-Language Pathology Services?

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

Do you offer an Additional Telehealth benefit for Yes

Part B services?

Select the Medicare-covered benefits that may have

Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1:

Individual Sessions for Psychiatric Services: 14e2:

Contrato Número

Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

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

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

No

Is authorization required for Additional Telehealth

Services?

Is a referral required for Additional Telehealth

Services?

No

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

No Is there an enrollee Copayment?

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

Is authorization required? No No

Is a referral required for Opioid Treatment Program

Services?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4 Is authorization required? Yes Is a referral required for Outpatient Diagnostic Yes Procedures/Test/Lab Services? SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Outpatient Yes Diagnostic/Therapeutic Radiological, and X-Ray Services? SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No PORNINISTRACIO Is authorization required for Medicare-covered Yes Outpatient Hospital Services? Is authorization required for Medicare-covered Nο Contrato Número Observation Services? Is a referral required for Medicare-covered Yes **Outpatient Hospital Services?** POSDE Is a referral required for Medicare-covered No Observation Services? SECTION B: #9B ASC SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #9B ASC SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required? Yes Is a referral required for Ambulatory Surgical Yes

Center Services?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Services as Yes

a supplemental benefit under Part C?

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

Select type of benefit for Three (3) Pint Deductible Mandatory

Waived:

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No

Is a referral required for Outpatient Blood Services? No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Yes

No

Mandatory

Does the plan provide Transportation Services as a

supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?





Indicate number of trips for Plan Approved Health-

related Location:

Select Plan Approved Health-related Location Trips

periodicity:

Select Type of Transportation for Plan Approved

Health-related Location:

Select Mode of Transportation for Plan Approved

Health-related Location:

Every year

10

One-way

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? No No

Is a referral required for Transportation Services?

Notes: Transportation to Plan-Approved Location provided

by contracted transportation provider, who will

verify remaining trip balance.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Copayment?

SECTION B: #11A DME - BASE 2

Yes

No

Are there preferred vendors/manufacturers for

Durable Medical Equipment (DME)?

Yes Is authorization required?

Notes: Pre-authorization by PCP (for corresponding

> services) is managed through Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

No Is there an enrollee Coinsurance?

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

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

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

Yes Is authorization required?

Notes:

. .

The PBP will implement a Part D RI program in accordance with any final Application Proposal approved by CMMI.





4

Describe the components of your pharmacy network (select all that apply):

Sponsor attests that it will comply with 42 CFR 423.154.

: Standard Retail: Out-of-Network: Standard Mail-

Order: Long-Term Care

: Sponsor attests that it will comply with 42 CFR

423,154.

SECTION RX	MEDICARE	RX CENERA	1.2
			4

Does plan utilize floor pricing? No Does plan utilize ceiling pricing? No Are there quantity limits on certain prescription Yes

drugs?

Is prior authorization required for certain prescription drugs?

Will your plan be limiting on-formulary coverage of

drugs to certain indications (i.e., are you implementing indication-based formulary design)?

Do any drugs in your formulary require a step

therapy plan?

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

No

Yes

Yes

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing Standard Retail Cost Sharing - 2 month Supply: Location/supply amount(s) that apply:

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order Cost

Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month

Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill? : Standard Retail Cost Sharing - 1 month Supply:

Standard Retail Cost Sharing - 3 month Supply

30

60

90

: Out-of-Network Pharmacy - one month supply

Contrato Número

30

90

: Standard Mail-Order - 3-month supply

: Long-Term Care Pharmacy

31

No

Yes

SECTION RX: MEDICARE RX - NOTES



SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE #1 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

Is a referral required for General Supports for

Is authorization required?

No

No

Living?

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

Notes: General Supports for Living contains two separate

benefits: (1) Home Assistance - Eight (8) visits per

year (two per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith) and categories

listed under Pest Control. (2) Subsidy for Electricity/Water/Telephone/Internet/Gas

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

No

Is there an In-Network Plan Deductible?

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

Yes

Voluntary

3400.00

Is there an In-Network Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicare-

covered plan services?

: In-Network Medicare-covered benefits

ledicare..

SECTION D: MAX PLAN BENEFIT COVERAGE

No

Yes

Is there a Maximum Plan Benefit Coverage

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing? No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with No

uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Yes

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit: Defined Standard

8

Contrato Número

n

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

Yes

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

C?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Location: Mandatory

Is this benefit unlimited for number of trips for

Indicate number of trips for Plan-approved

Plan-approved Location?

0

No

Location:

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

Needs for Plan-approved Location:

Select Mode of Transportation for Non-Medical

Need for Plan-approved Location:

: Medical Transport: Other, Describe

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

No

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

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

Medical Needs?

Notes: Fleet includes 4-door sedans, minivans, buses with

> hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i -Transportation for Non-Medical Needs, if the

beneficiary qualifies for SSBCI.

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

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Yes

Mandatory











SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce: Pest Control: Transportation for Non-Medical Needs: General Supports for

Living

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

Does the plan provide Food and Produce as a

supplemental benefit under Part C?

Yes

Select type of benefit for Food and Produce:

No

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Mandatory

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

Is a referral required for Food and Produce?

No

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: Food and Produce is a subsidy for groceries.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

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

Yes

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Pest Control?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes:

Services listed in this category will be combined with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following options: - Pest Control - Preventive home cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General Supports for Living")

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Notes:

Benefit and Maximum Plan Coverage Amount

includes benefit for repair of devices.

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

Does your plan include MA Uniformity Flexibility

No

with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the

Chronically Ill?

Yes

Select what type of benefit your SSBCI includes: : Additional Benefits

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

Does your VBID/MA Uniformity Flexibility/SSBCI

benefit offer additional Part C benefits?

Yes

How many packages do your Additional Benefits

contain? (1-15)

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

1

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

Is there a prerequisite for any additional benefits for

this package?

No

Select all the Non-Medicare-covered additional

: 13i: Non-Primarily Health Related Benefits for the

benefits offered in this package:

Chronically Ill

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

Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement? No
Is there a maximum benefit amount? Yes
Specify the maximum benefit amount: 80.00

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

Notes:



The following SSBCI benefits will be offered: Food and Produce - Subsidy for Groceries - Pest
Control - Transportation for Non-Medical Needs General Supports for Living: (1) Home Assistance
Services (2) Subsidy for Electricity, Water, Phone,
Internet, Gas Maximum benefit coverage
periodicity is every three months. Maximum benefit
amount is for the combination of two benefits,
"Food and Produce" and "Subsidy for Electricity,
Water, Phone, Internet, Gas". Amount does not roll
over/accumulate from one period to the next.
Maximum benefit amount does not apply to "Home

Assistance Services".



Indicate number for Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

1

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

No

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

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)?

No. indicate number

Indicate quantity for Hearing Aids (all types): 2

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

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

2000.00 Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-

No

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18B HEARING AIDS - BASE 4

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

SECTION B: #18B HEARING AIDS - BASE 5

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



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Is this benefit unlimited for Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

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

SECTION B: #17B EYEWEAR - BASE 3

Yes

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Select the Maximum Plan Benefit Coverage type:

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Plan-specified amount per period

Yes

Every year

500.00

SECTION B: #17B EYEWEAR - BASE 4

No

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for Eyewear? No

Notes: Eyewear benefit maximum amount includes repair

> of evewear. Provider and/or member must verify remaining combined maximum plan benefit

> > SMINISTRACIO

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coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Yes

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams: Fitting/Evaluation for

Hearing Aid

Select type of benefit for Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

Exams?

Mandatory

No, indicate number

Indicate number for Routine Hearing Exams:

Select Routine Hearing Exams periodicity:

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

1

Every year

Mandatory

No, indicate number



Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes

Is a referral required for Comprehensive Dental No

Services?

Notes: Coverage for crowns included under "Other

Services". The replacement of a removable dental prosthesis will be covered five years after its initial insertion. The member who does not comply with the stated five-year term from the initial insertion, may use the Maximum Plan Benefit Coverage amount for services related to his/her removable

prosthesis.

SECTION B: #17A EYE EXAMS - BASE 1

Yes

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

Select type of benefit for Routine Eye Exams: Mandatory

Is this benefit unlimited for Routine Eye Exams?

Indicate number of exams for Routine Eye Exams:

Select the Routine Eye Exams periodicity: Ey

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

TD ...

No, indicate number

Every year

No

No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No
Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

Does the plan provide Eyewear as a supplemental

benefit under Part C?

Select enhanced benefits:

Yes

enem under Part C?

: Contact lenses: Eyeglasses (lenses and frames):

Eyeglass lenses: Eyeglass frames

Select type of benefit for Contact lenses:

Mandatory

Is this benefit unlimited for Contact lenses?

Yes

Select type of benefit for Eyeglasses (lenses and

Mandatory

frames):





SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory

No

supplemental benefit?

Select enhanced benefits:

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

No

Yes

Does the plan provide Preventive Dental Items as a

supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items

as a supplemental benefit under Part C?

: 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:

Select the Diagnostic Services periodicity: Every six months

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:

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

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

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage

periodicity:

2000.00

Every year

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Therapeutic Massage Notes:*

Therapeutic massage is limited to six (6) visits per year and must be ordered by a physician or medical

professional.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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

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

Services?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

No

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

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?

Is authorization required for Other Medicare- No

covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

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





Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

Select type of benefit for Therapeutic Massage:

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit

No

No

Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

No

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

Is authorization required?

No No

Is a referral required for Other Defined

Supplemental Benefits?

Health Education Notes:

Route to Wellness - Health and preventive workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta - Guidance on preventive measures and actions to take in case of natural disasters and to reduce health

complications.

Nutritional/Dietary Benefit Notes:

Personal evaluation and diet plan designed by licensed dietitian according to patient's health

needs, including exercise suggestions.

Fitness Benefit Notes:* Route to Wellness - Exercise and Nutrition

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Education Interventions. Member has access to fitness classes to promote physical activity and a

healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies flu among others

allergies, flu, among others.

Remote Access Technologies (Nursing Hotline)

Notes:

MCS MedilÃnea- Nursing Hotline.

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

Alternative Therapies Notes:*

Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.

SECTION B: #13C MEAL BENEFIT - BASE 1

No

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.

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

Medicare-covered Zero Dollar Preventive Services

Attestation

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

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical Exam as

a supplemental benefit under Part C?

No

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

Yes

Does the plan provide Other Defined Supplemental

Benefits as a benefit under Part C?

Select enhanced benefit (Select all that apply): : 14c1: Health Education: 14c2: Nutritional/Dietary

> Benefit: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*: 14c17: Alternative Therapies*: 14c18: Therapeutic

Massage*

6

Select type of benefit for Health Education: Mandatory Mandatory

Select type of benefit for Nutritional/Dietary

Is this benefit unlimited for Nutritional/Dietary

Benefit:

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Benefit?

Indicate setting for Nutritional/Dietary Benefit: **Individual Sessions**

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

Mandatory

: Physical Fitness

Select type of benefit for Remote Access Mandatory

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

: Web/Phone-based technologies: Nursing Hotline

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

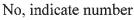
6

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative Therapies?

Indicate number of visits offered for Alternative

Therapies:





Contrato Número

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Is a referral required for Dialysis Services?

No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Treatments: Mandatory

Is this benefit unlimited for Number of Treatments? No Indicate limit for Number of Treatments: 6

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

No

Is your Acupuncture benefit combined with either the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Yes

Yes

125.00

Select type of benefit for OTC Items:

Mandatory

Is there a service-specific Maximum Plan Benefit

Coverage amount?

unt.

Indicate Maximum Plan Benefit Coverage amount:

Every month

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Select Maximum Plan Benefit Coverage

periodicity:

No

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

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Are you offering Nicotine Replacement Therapy

No

(NRT) as a Part C OTC benefit?

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

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?

Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #11A DME - BASE 2 Are there preferred vendors/manufacturers for Yes Durable Medical Equipment (DME)? Is authorization required? Yes Pre-authorization by PCP (for corresponding Notes: services) is managed through Referral/Authorization Form. SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? No Is there an enrollee Coinsurance? SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 3 Is authorization required? Yes Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE Is there an enrollee Copayment? No Do you limit Diabetic Supplies and Services to Yes those from specified manufacturers? Is authorization required? Yes Pre-authorization by PCP (for corresponding Notes: services) is managed through Referral/Authorization Form. **SECTION B: #12 DIALYSIS SERVICES - BASE 1** Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

No

Is authorization required?

Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Outpatient Blood Services? No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Yes Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Yes

No

Does the plan provide Transportation Services as a

supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Mandatory

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?

Indicate number of trips for Plan Approved Health-24

related Location:

Every year

Select Plan Approved Health-related Location Trips periodicity:

One-way

Select Type of Transportation for Plan Approved

Health-related Location:

Select Mode of Transportation for Plan Approved

Health-related Location:

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

No

No

Is there a service-specific Maximum Plan Benefit

Is there a service-specific Maximum Enrollee Out-

Coverage amount?

of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? No No

Is a referral required for Transportation Services?

Transportation to Plan-Approved Location provided Notes:

by contracted transportation provider, who will

verify remaining trip balance.

SECTION B: #11A DME - BASE 1



Is there an enrollee Coinsurance?

No

No

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

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

Outpatient Hospital Services?

Is authorization required for Medicare-covered

Observation Services?

Is a referral required for Medicare-covered Yes

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

Yes
Is a referral required for Ambulatory Surgical

Yes

Center Services?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Services as Yes

a supplemental benefit under Part C?

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

Select type of benefit for Three (3) Pint Deductible Mandatory

Waived:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

No

No





SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3 Is authorization required for Additional Telehealth No Services? Is a referral required for Additional Telehealth No Services? DMINISTRAC/O SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Contrato Número Is there an enrollee Coinsurance? No 21 - 00Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2 Is authorization required? No Is a referral required for Opioid Treatment Program No Services? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee Coinsurance? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4 Is authorization required? Yes Is a referral required for Outpatient Diagnostic Yes Procedures/Test/Lab Services? Lab Services Notes: No referral required for services within the Special Network, our preferred network. SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Outpatient Yes Diagnostic/Therapeutic Radiological, and X-Ray Services? SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost?

Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2 Is authorization required? No Is a referral required for Other Health Care Yes **Professional Services?** SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3** Is authorization required? Yes Is a referral required for Psychiatric Services? No Notes: Preauthorization required through MCS Solutions. SECTION B: #7I PT AND SP SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Contrato Número Is there an enrollee Coinsurance? No No Is there an enrollee Deductible? Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2 Is authorization required? Yes Is a referral required for Physical Therapy and Yes Speech-Language Pathology Services? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 1 Do you offer an Additional Telehealth benefit for Yes Part B services? Select the Medicare-covered benefits that may have : 7a: Primary Care Physician Services: 7d: Additional Telehealth Benefits available: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1: Individual Sessions for Psychiatric Services: 14e2:

Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No



Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Occupational Therapy

Services?

Yes

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

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Physician Specialist

Yes

Services?

Notes:

No referral required for services within the Special

Network, our preferred network.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

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

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

Is authorization required?

Yes

Is a referral required for Mental Health Specialty

No

Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

No

supplemental benefit under Part C?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

Notes: No referral required for services within the Special

Network, our preferred network.

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



Notes:

Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes Is a referral required for Home Health Services? Yes

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Yes

No

No

: Routine Care

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

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:

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined

with either the Acupuncture or Alternative

Therapies benefit, or both?

Select enhanced benefit:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is authorization required? No Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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





Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

No

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

No Is there an enrollee Copayment?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Does the plan provide Worldwide Yes

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: * Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Mandatory

Mandatory

Select type of benefit for Worldwide Emergency

Coverage:

Coverage:

Is there a Maximum Plan Benefit Coverage amount

for Worldwide Emergency/Urgent Coverage?

Select type of benefit for Worldwide Urgent

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

No

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

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

Coverage is managed through reimbursement based Notes:

on different fee schedules allowed by our plan, less

Contrato Mismi

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

Is there an enrollee Deductible? No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No

Is authorization required? Yes

Is a referral required for Partial Hospitalization? No Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

What is your Inpatient Hospital Psychiatric benefit

period?

Original Medicare

Yes

Is a referral required for Inpatient Psychiatric

Hospital Services?

Is authorization required?

No

Notes: Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

No

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay

prior to SNF admission?

Yes

Zero

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

No

No

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?

Is there an enrollee Coinsurance?

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

No

Original Medicare

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period?

Is authorization required? Yes

Is a referral required for SNF Services? Yes

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

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

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

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

Is authorization required?

Yes



Customer Service Contact Local TTY/TDD for (866)627-8182 Current Part D Medicare Beneficiaries: Customer Service Contact TTY/TDD for (866)627-8182 Prospective Part D Medicare Beneficiaries: Customer Service Contact Local TTY/TDD for (866)627-8182 Prospective Part D Medicare Beneficiaries: **SECTION A: SECTION A-5** Is your organization filing a standard bid for Section No B of the PBP? Is your organization filing a standard bid for Section No C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for Section No D of the PBP? Do any of your outpatient services have tiered cost No sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software) SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1 Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part C? SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee obtains care? Is there an enrollee Coinsurance? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12 What is your Inpatient Hospital-Acute benefit Original Medicare Contrato Número period? Is authorization required? Yes Is a referral required for Inpatient Hospital-Acute Yes CROSDE Services? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1 Does the plan provide Inpatient Hospital Psychiatric No Services as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-No

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

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

of-Pocket Cost?

No



Indicate CY2021 total projected member months for 16377

this plan:

Does this Plan have a CMS-approved Continuation No

Area?

Do you intend to participate in the PLATINO Yes

program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

Is this D-SNP plan a Medicare zero-dollar cost

sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all

Medicare premiums and cost sharing for enrollees

in your D-SNP?

SECTION A: SECTION A-3

No

Yes

Participating Pharmacy Website Address: www.mcsclassicare.com

Formulary Website Address: www.mcsclassicare.com
Physician Website Address: www.mcsclassicare.com

Customer Service Contact Phone Number for (866)627-8183

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8183

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Part D Medicare Beneficiaries:

Customer Service Contact TTY/TDD for Current (866)627-8182

Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (866)627-8182

Current Medicare Beneficiaries:

Customer Service Contact TTY/TDD for (866)627-8182

Prospective Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (866)627-8182

Prospective Medicare Beneficiaries:

Customer Service Contact TTY/TDD for Current (866)627-8182

Part D Medicare Beneficiaries:





	SECTION A: SECTION A-2
Is this an Employer-Only plan?	No
Plan Geographic Name:	Puerto Rico
Contract Period:	2021
Segment ID:	0
Plan ID:	037
Contract Number:	H5577
Service Area(s):	40770 - Yauco, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40740 - Viegues, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40420 - Las Piedras, PR



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

40020 - Aguada, PR 40030 - Aguadilla, PR 40040 - Aguas Buenas, PR 40050 - Aibonito, PR 40060 - Anasco, PR 40070 - Arecibo, PR 40080 - Arroyo, PR 40090 - Barceloneta, PR 40100 - Barranquitas, PR 40110 - Bayamon, PR 40120 - Cabo Rojo, PR 40130 - Caguas, PR 40140 - Camuy, PR 40145 - Canovanas, PR 40150 - Carolina, PR 40160 - Catano, PR 40170 - Cayey, PR 40180 - Ceiba, PR 40190 - Ciales, PR 40200 - Cidra, PR 40210 - Coamo, PR 40220 - Comerio, PR 40230 - Corozal, PR 40240 - Culebra, PR 40250 - Dorado, PR 40260 - Fajardo, PR 40265 - Florida, PR 40270 - Guanica, PR 40280 - Guayama, PR 40290 - Guayanilla, PR 40300 - Guaynabo, PR 40310 - Gurabo, PR 40320 - Hatillo, PR 40330 - Hormigueros, PR 40340 - Humacao, PR 40350 - Isabela, PR 40360 - Jayuya, PR 40370 - Juana Diaz, PR 40380 - Juncos, PR

40390 - Lajas, PR 40400 - Lares, PR

40410 - Las Marias, PR







PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/27/2020 05:47:16 PM SA Western Standard

Time

MA BPT Timestamp: 05/30/2020 04:45:01 PM SA Western Standard

Time

PD BPT Timestamp: 05/30/2020 04:45:02 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/30/2020 04:49:39 PM SA Western Standard

Time

Upload Status: 05/30/2020 #01806

PLAN STATUS

Section A Status Plan Ready for Upload

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

Section B9 Status Completed
Section B10 Status Completed
Section B11 Status Completed
Section B12 Status Completed
Section B13 Status Completed

Section B13 Status Completed
Completed

Section B15 Status Completed
Section B16 Status Completed

Section B17 Status Completed
Section B18 Status Completed

Section B19 Status Completed
Section C Status Completed

Section D Status Completed
Section Mrx Status Completed

SECTION A: SECTION A-1

Contrato Número

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Organization Web Site: www.mcsclassicare.com

Plan Name: MCS Classicare Platino @Home (HMO D-SNP)

Organization Type: Local CCP

Plan Type: HMO

Enrollee Type: Part A and Part B

Service Area(s): 40010 - Adjuntas, PR

Is prior authorization required for certain Yes prescription drugs? Will your plan be limiting on-formulary coverage of No drugs to certain indications (i.e., are you implementing indication-based formulary design)? Do any drugs in your formulary require a step Yes therapy plan? Do you pay for over-the-counter medications No (OTCs) under the utilization management program? SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply: Location/supply amount(s) that apply: Standard Retail Cost Sharing - 2 month Supply: Standard Retail Cost Sharing - 3 month Supply Enter number of days for Standard Retail Cost Sharing 1-month supply: Enter number of days for Standard Retail Cost 60 Sharing 2-month supply: Enter number of days for Standard Retail Cost 90 Sharing 3-month supply: Select all Out-of-Network Pharmacy Out-of-Network Pharmacy - one month supply Location/supply amount(s) that apply: Enter number of days for Out-of-Network 30 Pharmacy 1-month supply: Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 3-month supply Location/supply amount(s) that apply: Enter number of days for Standard Mail-Order Cost 90 Sharing 3-month supply: Select the Long-Term Care Pharmacy one month : Long-Term Care Pharmacy - 1-month supply Location/supply amount(s) that apply: Enter number of days for Long-Term Care 31 Pharmacy 1-month supply: Are all of the drugs on your formulary available Contrato Número No with an extended day supply? Are any of the drugs available at an extended day Yes supply limited to a 1-month supply for the first fill? POSDE **SECTION RX: MEDICARE RX - NOTES** Notes: The PBP will implement a Part D RI program in accordance with any final Application Proposal approved by CMMI. DATA REPORT FOR Contract H5577, PLAN 037, SEGMENT 0 Module: **PBP** Requested By: d3ua PLAN SYSTEM INFORMATION

05/27/2020

Last entry Date:

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

General Supports for Living contains two separate Notes:

benefits: (1) Home Assistance - Eight (8) visits per

year (two per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith) and categories

listed under Pest Control. (2) Subsidy for Electricity/Water/Telephone/Internet/Gas

SECTION C: V/T - GENERAL - US

No

Do you offer a US Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

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

Yes

Is there an In-Network Maximum Enrollee Out-of-

Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicarecovered plan services?

Voluntary

3400.00

: In-Network Medicare-covered benefits

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

Amount?

No

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with No

uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Yes

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Select the type of drug benefit: Defined Standard

Describe the components of your pharmacy network

(select all that apply):

Order: Long-Term Care

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

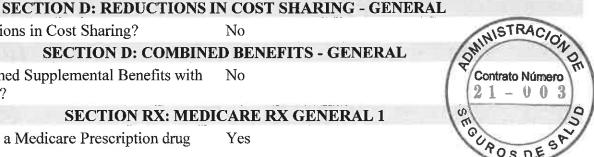
423,154.

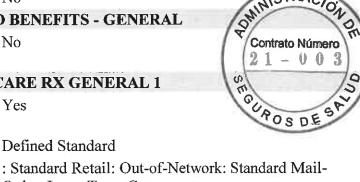
SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? No Does plan utilize ceiling pricing? No

Are there quantity limits on certain prescription Yes

drugs?





Indicate number of trips for Plan-approved

Location:

Select Plan-approved Location Trips periodicity:

Select Type of Transportation for Non-Medical

Needs for Plan-approved Location:

Select Mode of Transportation for Non-Medical

Need for Plan-approved Location:

0

Every year

One-way

: Medical Transport: Other, Describe

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

No

No No

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Transportation for Non-

Medical Needs?

No

Notes: Fleet includes 4-door sedans, minivans, buses with

hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i -

Transportation for Non-Medical Needs, if the

beneficiary qualifies for SSBCI.

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

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Yes

Mandatory

No

No

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

#1 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 No Living?



TRACION

Contrato Número

_ 0 0

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

No

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

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

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: Food and Produce is a subsidy for groceries.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Yes

No

No

Does the plan provide Pest Control as a

supplemental benefit under Part C?

Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? Is authorization required? No Is a referral required for Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Services listed in this category will be combined Notes:

with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following

options: - Pest Control - Preventive home

cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General

Supports for Living")

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

Yes

No

Does the plan provide Transportation for Non-

Medical Needs as a supplemental benefit under Part

C?

Plan-approved Location Select enhanced benefit:

Select type of benefit for Plan-approved Location: Mandatory

Is this benefit unlimited for number of trips for

Plan-approved Location?



Contrato Número

- 0 0 3

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

Does your VBID/MA Uniformity Flexibility/SSBCI Yes

benefit offer additional Part C benefits?

How many packages do your Additional Benefits

contain? (1-15)

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

1

#1

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

benefits offered in this package:

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

Is there a prerequisite for any additional benefits for

No

this package?

Select all the Non-Medicare-covered additional

: 13i: Non-Primarily Health Related Benefits for the

Chronically Ill

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

Are any benefits exempt from the plan-level

No

deductible?

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

No

Are you offering retroactive reimbursement?

Is there a maximum benefit amount? Yes

Specify the maximum benefit amount: 300.00

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

Notes:

includes:



The following SSBCI benefits will be offered: Food and Produce - Subsidy for Groceries - Pest
Control - Transportation for Non-Medical Needs General Supports for Living: (1) Home Assistance
Services (2) Subsidy for Electricity, Water, Phone,
Internet, Gas Maximum benefit coverage
periodicity is every three months. Maximum benefit
amount is for the combination of two benefits,
"Food and Produce" and "Subsidy for Electricity,
Water, Phone, Internet, Gas". Amount does not roll
over/accumulate from one period to the next.
Maximum benefit amount does not apply to "Home

Assistance Services".

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill

: Food and Produce: Pest Control: Transportation for Non-Medical Needs: General Supports for

Living

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

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 an enrollee Deductible?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

No

No

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

SECTION B: #18B HEARING AIDS - BASE 1

Yes

Yes

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

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 No, indicate number

types)?

Indicate quantity for Hearing Aids (all types):

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Does the Maximum Plan Benefit Coverage Amount

apply per ear or for both ears combined?

Select the Maximum Plan Benefit Coverage type:

Indicate Maximum Plan Benefit Coverage amount:

Indicate Maximum Plan Benefit Coverage

periodicity:

Both ears combined

Plan-specified amount per period

2500.00

Every year



No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment? No

Is there an enrollee Deductible? No

SECTION B: #18B HEARING AIDS - BASE 5

Yes

Is authorization required? No

Is a referral required for Hearing Aids? Notes: Benefit and Maximum Plan Coverage Amount

includes benefit for repair of devices.

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

No

Yes

Does your plan include MA Uniformity Flexibility

with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the

Chronically Ill?

Select what type of benefit your SSBCI includes:

: Additional Benefits





SECTION B: #17B EYEWEAR - BASE 3 Is there a service-specific Maximum Plan Benefit Yes

Coverage amount?

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

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

600.00

Yes

Every year

SECTION B: #17B EYEWEAR - BASE 4

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No Is a referral required for Eyewear? No

Notes: Eyewear benefit maximum amount includes repair

> of eyewear. Provider and/or member must verify remaining combined maximum plan benefit

> > Contrato Número

coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Yes

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits: : Routine Hearing Exams: Fitting/Evaluation for

Hearing Aid

Mandatory Select type of benefit for Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing No, indicate number

Exams?

Indicate number for Routine Hearing Exams:

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

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No



Is a referral required for Comprehensive Dental

Services?

Notes: Coverage for crowns included under "Other

Services". The replacement of a removable dental prosthesis will be covered five years after its initial insertion. The member who does not comply with the stated five-year term from the initial insertion, may use the Maximum Plan Benefit Coverage amount for services related to his/her removable

prosthesis.

SECTION B: #17A EYE EXAMS - BASE 1

Yes

No

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Select enhanced benefit:

: Routine Eye Exams

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No
Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

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

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

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes





Does the plan provide Comprehensive Dental Items

as a supplemental benefit under Part C?

Select enhanced benefits: : Non-routine Services: Diagnostic Services:

Yes

Restorative Services: Endodontics: Periodontics:

OMINISTRACIO

Contrato Número

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:

Select the Diagnostic Services periodicity: Every six months

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:

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage type:

Indicate Maximum Plan Benefit Coverage amount:

Select the Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Plan-specified amount per period

2000.00

Every year

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

No

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes



Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease Education

No

Services?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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

No

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

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered No

Barium Enemas?

Is authorization required for Medicare-covered No

Digital Rectal Exams?

Is authorization required for Medicare-covered No

EKG following Welcome Visit?

Is authorization required for Other Medicare- No

covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services?

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

Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

No

Does the plan provide Part D home infusion drugs

as part of a bundled service as a mandatory

supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a No

supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1



SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental Benefits?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

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

Supplemental Benefits?

Health Education Notes: Route to Wellness - Health and preventive

Contrato Número

UROSDE

workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta -Guidance on preventive measures and actions to take in case of natural disasters and to reduce health

complications.

Nutritional/Dietary Benefit Not

Fitness Benefit Notes:*

Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.

Route to Wellness - Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.

Remote Access Technologies (Nursing Hotline) Notes:

MCS MedilAnea- Nursing Hotline.

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

Alternative Therapies Notes:* Foot reflexology is limited to six (6) visits per year

and must be ordered by a physician or medical

professional.

Therapeutic Massage Notes:* Therapeutic massage is limited to six (6) visits per year and must be ordered by a physician or medical

professional.

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No SECTION B: #14D - KIDNEY DISEASE EDUCATION SERVICES BASE 2



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 No

Is a referral required?

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

Does the plan provide the Annual Physical Exam as

a supplemental benefit under Part C?

No

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

Does the plan provide Other Defined Supplemental

Benefits as a benefit under Part C?

Yes

: 14c1: Health Education: 14c2: Nutritional/Dietary Select enhanced benefit (Select all that apply):

> Benefit: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline)*: 14c17: Alternative Therapies*: 14c18: Therapeutic

Massage*

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:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Fitness Benefit:

Individual Sessions

Mandatory

Indicate type of Fitness Benefit offered (Select all : Physical Fitness

that apply):

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

technologies and Nursing Hotline):

Mandatory

* Web/Phone-based technologies: Nursing Hotline

Select the type of Remote Access Technologies

offered (Select all that apply):

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

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:

Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

No

Select type of benefit for Therapeutic Massage: Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

No





Indicate Number of Treatments periodicity:

Every year

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is your Acupuncture benefit combined with either

the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

No

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items: Mandatory

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

60.00

Yes

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage

Every three months

periodicity:

Does your Maximum Plan Benefit Coverage

amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

No

No

No

SECTION B: #13B OTC ITEMS - BASE 2

Is there an enrollee Coinsurance?

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?

Contrato Número

21 - 00 3

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SECTION B: #13C MEAL BENEFIT - BASE 1

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



Pre-authorization by PCP (for corresponding Notes:

> services) is managed through Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

No

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Notes: Pre-authorization by PCP (for corresponding

> services) is managed through Referral/Authorization Form.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

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

Yes

Is there an enrollee Copayment? No

Do you limit Diabetic Supplies and Services to

those from specified manufacturers?

Is authorization required? Yes

Notes: Pre-authorization by PCP (for corresponding

> services) is managed through Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Treatments: Mandatory

Is this benefit unlimited for Number of Treatments? No Indicate limit for Number of Treatments: 6





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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Yes

Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a

supplemental benefit under Part C?

Plan Approved Health-related Location

Contrato Número 21 - 00

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Select type of benefit for Plan Approved Health-

Mandatory

Select enhanced benefit:

related Location:

No

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?

52

Indicate number of trips for Plan Approved Health-

related Location:

Select Plan Approved Health-related Location Trips

periodicity:

Every year

Select Type of Transportation for Plan Approved

Health-related Location:

One-way

Select Mode of Transportation for Plan Approved

Health-related Location:

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

Notes: Transportation to Plan-Approved Location provided

by contracted transportation provider.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

> No **SECTION B: #11A DME - BASE 2**

Are there preferred vendors/manufacturers for

Yes

Durable Medical Equipment (DME)?

Is there an enrollee Copayment?

Is authorization required?

Yes



Is a referral required for Medicare-covered

Outpatient Hospital Services?

Yes

Is a referral required for Medicare-covered

No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

Is authorization required? Yes Is a referral required for Ambulatory Surgical Yes

Center Services?

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

Is there a service-specific Maximum Enrollee Out-Nο

of-Pocket Cost?

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

Is there an enrollee Coinsurance? No

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

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

Is authorization required? No

Is a referral required for Outpatient Substance No

Abuse?

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

Mandatory

Does the plan provide Outpatient Blood Services as Yes

a supplemental benefit under Part C?

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

Select type of benefit for Three (3) Pint Deductible

Waived:

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

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

SECTION B: #10A AMBULANCE SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #10A AMBULANCE SERVICES - BASE 2



Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2 Is authorization required? No Is a referral required for Opioid Treatment Program No Services? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee Coinsurance? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 4 Is authorization required? Yes Is a referral required for Outpatient Diagnostic Yes Procedures/Test/Lab Services? SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BASE 3 Is authorization required? Yes Is a referral required for Outpatient Yes Diagnostic/Therapeutic Radiological, and X-Ray Services? SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No Is authorization required for Medicare-covered Yes Contrato Número **Outpatient Hospital Services?** _ 0 0 Is authorization required for Medicare-covered No Observation Services?

Is authorization required? No
Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

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

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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

Notes: Preauthorization required through MCS Solutions.

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes
Is a referral required for Physical Therapy and Yes

Speech-Language Pathology Services?

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

Yes

Do you offer an Additional Telehealth benefit for

Part B services?

Select the Medicare-covered benefits that may have

Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1:

0

POSDE

Individual Sessions for Psychiatric Services: 14e2: Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

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

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

Is authorization required for Additional Telehealth No

Services?

Is a referral required for Additional Telehealth No

Services?

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

Is authorization required? Yes Is a referral required for Occupational Therapy Yes

Services?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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

Is authorization required? No Is a referral required for Physician Specialist Yes

Services?

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

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

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

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

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

Is authorization required? Yes Is a referral required for Mental Health Specialty No

Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

No

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

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

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







SECTION B: #6 HOME HEALTH SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #6 HOME HEALTH SERVICES - BASE 2 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #6 HOME HEALTH SERVICES - BASE 3 Is authorization required? Yes Yes Is a referral required for Home Health Services? SECTION B: #7A PRIMARY CARE PHYSICIAN SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1 Does the plan provide Chiropractic Services as a Yes supplemental benefit under Part C? Select enhanced benefit: : Routine Care Select type of benefit for Routine Care: Mandatory Is this benefit unlimited for Routine Care? No, indicate number Indicate number of visits for Routine Care: 6 Select Routine Care periodicity: Every year Is your Chiropractor Services benefit combined No with either the Acupuncture or Alternative Contrato Número Therapies benefit, or both? Is there a service-specific Maximum Plan Benefit No Coverage amount? Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? **SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2** Is there an enrollee Coinsurance? No No Is there an enrollee Copayment? Is there an enrollee Deductible? No Is authorization required? No Is a referral required for Chiropractic Services? Yes SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1 Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? Is there an enrollee Coinsurance? No

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

No

No

Is there an enrollee Deductible?

Is there an enrollee Copayment?

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Yes

Is there an enrollee Copayment?

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

Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Mandatory

Select type of benefit for Worldwide Emergency

Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage amount No

for Worldwide Emergency/Urgent Coverage?

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

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

Notes: Coverage is managed through reimbursement based

on different fee schedules allowed by our plan, less

Contrato Número

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

Is there an enrollee Copayment? No
Is authorization required? Yes

Is authorization required? Yes
Is a referral required for Partial Hospitalization? No

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

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

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

Original Medicare

What is your Inpatient Hospital Psychiatric benefit

period?

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

Hospital Services?

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

No

Zero

No

No

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay Yes

prior to SNF admission?

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment? No

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Original Medicare Is authorization required? Yes

Is a referral required for SNF Services? Yes

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

No

Does the plan provide Cardiac and Pulmonary

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary No

Rehabilitation Services?







Customer Service Contact TTY/TDD for

(866)627-8182

Prospective Part D Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for

(866)627-8182

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-5

No

No

No

Is your organization filing a standard bid for Section

B of the PBP?

Is your organization filing a standard bid for Section

C of the PBP?

SECTION A: SECTION A-6

Is your organization filing a standard bid for Section

No

D of the PBP?

Do any of your outpatient services have tiered cost

sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section

B of the PBP software)

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

Does the plan provide Inpatient Hospital-Acute

No

Services as a supplemental benefit under Part C?

SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

No

No

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

obtains care?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible? No

Is there an enrollee Copayment? No

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

What is your Inpatient Hospital-Acute benefit

Original Medicare

period?

Yes Is authorization required?

Is a referral required for Inpatient Hospital-Acute Yes

Services?

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

Does the plan provide Inpatient Hospital Psychiatric No

Services as a supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

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

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

obtains care?

Is there an enrollee Coinsurance?

No

No

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





Does this Plan have a CMS-approved Continuation

Area?

Do you intend to participate in the PLATINO Yes

program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all

Medicare premiums and cost sharing for enrollees

in your D-SNP?

SECTION A: SECTION A-3

No

No

Yes

Participating Pharmacy Website Address: www.mcsclassicare.com

Formulary Website Address: www.mcsclassicare.com

Physician Website Address: www.mcsclassicare.com

Customer Service Contact Phone Number for (866)627-8183

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8183

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number for (787)620-2530

Current Part D Medicare Beneficiaries:

Customer Service Contact Phone Number for (866)627-8181

Prospective Part D Medicare Beneficiaries:

SECTION A: SECTION A-4

Customer Service Contact Local Phone Number for (787)620-2528

Prospective Part D Medicare Beneficiaries:

Customer Service Contact TTY/TDD for Current (866)627-8182

Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (866)627-8182

Current Medicare Beneficiaries:

Customer Service Contact TTY/TDD for (866)627-8182

Prospective Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (866)627-8182

Prospective Medicare Beneficiaries:

Customer Service Contact TTY/TDD for Current (866)627-8182

Part D Medicare Beneficiaries:

Customer Service Contact Local TTY/TDD for (866)627-8182

Current Part D Medicare Beneficiaries:





Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR
Service Area(s):	40570 - Quebradillas, PR
Service Area(s):	40580 - Rincon, PR
Service Area(s):	40590 - Rio Grande, PR
Service Area(s):	40610 - Sabana Grande, PR
Service Area(s):	40620 - Salinas, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40640 - San Juan, PR
Service Area(s):	40650 - San Lorenzo, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40670 - Santa Isabel, PR
Service Area(s):	40680 - Toa Alta, PR
Service Area(s):	40690 - Toa Baja, PR
Service Area(s):	40700 - Trujillo Alto, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40740 - Vieques, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40760 - Yabucoa, PR
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5577
Plan ID:	036
Segment ID:	0
Contract Period:	2021
Plan Geographic Name:	Puerto Rico
Is this an Employer-Only plan?	No
SECTION A	SECTION A-2
Indicate CY2021 total projected member months for this plan:	13800





Service Area(s):	40030 - Aguadilla, PR
Service Area(s):	40040 - Aguas Buenas, PR
Service Area(s):	40050 - Aibonito, PR
Service Area(s):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40080 - Arroyo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40100 - Barranquitas, PR
Service Area(s):	40110 - Bayamon, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40130 - Caguas, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40145 - Canovanas, PR
Service Area(s):	40150 - Carolina, PR
Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
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05/30/2020 03:10:36 PM SA Western Standard Plan Ready for Upload Timestamp:

Time

05/30/2020 04:44:59 PM SA Western Standard MA BPT Timestamp:

Time

PD BPT Timestamp: 05/30/2020 04:45:00 PM SA Western Standard

Time

Last Upload File Creation Timestamp: 05/30/2020 04:49:39 PM SA Western Standard

Time

Upload Status: 05/30/2020 #01806

PLAN STATUS

Section A Status Plan Ready for Upload

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed Section B5 Status Completed Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed

Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed

Section C Status Completed Section D Status Completed

Section Mrx Status Completed

SECTION A: SECTION A-1

MCS ADVANTAGE, INC. Organization Legal Name:

Organization Marketing Name: MCS Classicare

www.mcsclassicare.com Organization Web Site:

MCS Classicare Platino Recarga (HMO D-SNP)

Local CCP

HMO

Part A and Part B

40010 - Adjuntas, PR

40020 - Aguada, PR

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Plan Name:

Organization Type: Plan Type:

Enrollee Type:

Service Area(s):

Service Area(s):

Will your plan be limiting on-formulary coverage of No drugs to certain indications (i.e., are you implementing indication-based formulary design)? Do any drugs in your formulary require a step Yes therapy plan? No Do you pay for over-the-counter medications (OTCs) under the utilization management program?

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing : Standard Retail Cost Sharing - 1 month Supply: Standard Retail Cost Sharing - 2 month Supply: Location/supply amount(s) that apply: Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost 30

Sharing 1-month supply:

Enter number of days for Standard Retail Cost 60

Sharing 2-month supply:

Enter number of days for Standard Retail Cost 90

Sharing 3-month supply:

Select all Out-of-Network Pharmacy : Out-of-Network Pharmacy - one month supply

Location/supply amount(s) that apply:

Enter number of days for Out-of-Network 30

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing : Standard Mail-Order - 3-month supply

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order Cost 90

Sharing 3-month supply:

: Long-Term Care Pharmacy - 1-month supply RACION Select the Long-Term Care Pharmacy one month

Location/supply amount(s) that apply:

Enter number of days for Long-Term Care 31

Pharmacy 1-month supply:

Are all of the drugs on your formulary available No

Notes:

with an extended day supply? Yes

Are any of the drugs available at an extended day

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

SECTION RX: MEDICARE RX - NOTES

The PBP will implement a Part D RI program in

accordance with any final Application Proposal

approved by CMMI.

DATA REPORT FOR Contract H5577, PLAN 036, SEGMENT 0

Module: **PBP** d3ua Requested By:

PLAN SYSTEM INFORMATION

05/30/2020 Last entry Date: PBP Software Version: 2021.01



Contrato Número

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

Home Assistance - Eight (8) visits per year (two per Notes:

quarter) for Home Assistance (Plumbing,

Electricity, Locksmith) and categories listed under

Pest Control.

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

No

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

Is there an In-Network Plan Deductible? No

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

Is there an In-Network Maximum Enrollee Out-of-

Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

Voluntary

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

3400.00

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-

covered plan services?

fil MISTRACION In-Network Medicare-covered benefit

Yes

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

Amount?

No

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with

uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Yes

Select the type of drug benefit: Defined Standard

Describe the components of your pharmacy network

(select all that apply):

: Standard Retail: Out-of-Network: Standard Mail-

Order: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR

423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing? No Does plan utilize ceiling pricing? No Are there quantity limits on certain prescription Yes

drugs?

Is prior authorization required for certain

prescription drugs?

Yes



Contrato Número

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Indicate number of trips for Plan-approved

Location:

Every year

Select Plan-approved Location Trips periodicity:

Select Type of Transportation for Non-Medical

Needs for Plan-approved Location:

One-way

0

Select Mode of Transportation for Non-Medical

Need for Plan-approved Location:

: Medical Transport: Other, Describe

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

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

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

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

Medical Needs?

Notes:

Fleet includes 4-door sedans, minivans, buses with

hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i -

Transportation for Non-Medical Needs, if the

beneficiary qualifies for SSBCI.

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

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?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for General Supports for
Living?



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Contrato Número

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

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

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

Notes: The following SSBCI benefits will be offered: -

> Pest Control - Transportation for Non-Medical Needs - General Supports for Living: (1) Home

: Pest Control: Transportation for Non-Medical

Assistance Services

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill

Needs: General Supports for Living

includes:

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

Does the plan provide Pest Control as a

Yes

supplemental benefit under Part C? Select type of benefit for Pest Control:

Mandatory

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE

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 Pest Control? No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Services listed in this category will be combined Notes:

with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following

options: - Pest Control - Preventive home

cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General

Supports for Living")

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

Does the plan provide Transportation for Non-

Yes

Medical Needs as a supplemental benefit under Part

C?

Select enhanced benefit:

Plan-approved Location

Select type of benefit for Plan-approved Location:

Mandatory

Is this benefit unlimited for number of trips for

No

Plan-approved Location?



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Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Yes

Indicate Maximum Plan Benefit Coverage

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #18B HEARING AIDS - BASE 5

Is authorization required?

No

Is a referral required for Hearing Aids?

Yes

Notes:

Benefit and Maximum Plan Coverage Amount

includes benefit for repair of devices.

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

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?

Yes

Select what type of benefit your SSBCI includes:

: Additional Benefits

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

Does your VBID/MA Uniformity Flexibility/SSBCI

benefit offer additional Part C benefits?

Yes

How many packages do your Additional Benefits

contain? (1-15)

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

1

#1

Is this package applicable to VBID or MA

SSBCI

Uniformity Flexibility or SSBCI?

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

Is there a prerequisite for any additional benefits for

this package?

No

Select all the Non-Medicare-covered additional

: 13i: Non-Primarily Health Related Benefits for the

benefits offered in this package:

Chronically Ill

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

Are any benefits exempt from the plan-level

No

deductible?





Is a referral required for Eyewear?

No

Notes:

Eyewear benefit maximum amount includes repair of evewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

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

No, indicate number

Exams?

Indicate number for Routine Hearing Exams: 1

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

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

1

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there an enrollee Deductible? No

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a

supplemental benefit under Part C?

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

No, indicate number

types)?

Indicate quantity for Hearing Aids (all types): 2

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2





Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No
Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

Yes

Does the plan provide Eyewear as a supplemental

benefit under Part C?

Select enhanced benefits:

: Contact lenses: Eyeglasses (lenses and frames):

Eyeglass lenses: Eyeglass frames

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

Yes

Yes

Is this benefit unlimited for Eyeglasses (lenses and

frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses?

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes

SECTION B: #17B EYEWEAR - BASE 3

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

Indicate Combined Maximum Plan Benefit

Coverage Amount for all Eyewear?

Yes

200.00

Coverage amount:

Select the Combined Maximum Plan Benefit

Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required?





Is this benefit unlimited for Restorative Services? No, indicate number

Indicate number of visits for Restorative Services:

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit Yes

Coverage amount?

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

Indicate Maximum Plan Benefit Coverage amount: 2000.00 Every year

Select the Maximum Plan Benefit Coverage

periodicity:

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

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

Services?

Notes: Prosthodontics not covered.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Yes

1

No

Select enhanced benefit: : Routine Eye Exams

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:

Select the Routine Eye Exams periodicity: Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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Contrato Número



Is there an enrollee Copayment? No Is authorization required for Medicare-covered No Glaucoma Screening? Is authorization required for Medicare-covered No Diabetes Self-Management Training? Is authorization required for Medicare-covered No **Barium Enemas?** Is authorization required for Medicare-covered No Digital Rectal Exams? Is authorization required for Medicare-covered No EKG following Welcome Visit? Is authorization required for Other Medicare-No covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is Authorization Required? Yes Does the plan offer step therapy? Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

No

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory

supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

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

Select enhanced benefits: : Non-routine Services: Diagnostic Services:

Restorative Services: Endodontics: Periodontics:

Extractions: Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine 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:

Select the Diagnostic Services periodicity: Every six months

Select type of benefit for Restorative Services: Mandatory







Health Education Notes:

Fitness Benefit Notes:*



Nutritional/Dietary Benefit Notes:

Route to Wellness - Health and preventive workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta -Guidance on preventive measures and actions to take in case of natural disasters and to reduce health complications.

Personal evaluation and diet plan designed by licensed dietitian according to patient's health

needs, including exercise suggestions.

Route to Wellness - Exercise and Nutrition

Education Interventions. Member has access to fitness classes to promote physical activity and a

healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.

Remote Access Technologies (Nursing Hotline)

MCS MedilAnea- Nursing Hotline.

Notes:

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

Foot reflexology is limited to six (6) visits per year Alternative Therapies Notes:*

and must be ordered by a physician or medical

professional.

Therapeutic Massage Notes:* Therapeutic massage is limited to six (6) visits per

year and must be ordered by a physician or medical

professional.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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

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?

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

No

Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

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



Alternative Therapies*: 14c18: Therapeutic

Massage*

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary

Benefit:

Individual Sessions

Indicate setting for Nutritional/Dietary Benefit:

Mandatory

6

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

: Physical Fitness

No, indicate number

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):

: Web/Phone-based technologies: Nursing Hotline

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative Therapies?

Indicate number of visits offered for Alternative

Therapies:

No

6

Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

Select type of benefit for Therapeutic Massage:

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

No

No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance? No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

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

Supplemental Benefits?

No



Is a referral required for Acupuncture?

Nο

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage amount:

Select Maximum Plan Benefit Coverage

periodicity:

Does your Maximum Plan Benefit Coverage

amount carry forward to the next period if it is

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Mandatory

Yes

20.00

Every three months

No

No No

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive Services

Attestation

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

Is authorization required? No Is a referral required? No

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

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

No

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

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: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline)*: 14c17:



Notes: Pre-authorization by PCP (for corresponding

> services) is managed through Referral/Authorization Form.

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

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

Yes

Is there an enrollee Copayment? No

Do you limit Diabetic Supplies and Services to

those from specified manufacturers?

Is authorization required? Yes

Pre-authorization by PCP (for corresponding Notes:

> services) is managed through Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Yes

No

No

No

Does the plan provide Acupuncture as a

supplemental benefit under Part C?

: Number of Treatments Select enhanced benefit:

Select type of benefit for Number of Treatments: Mandatory

Is this benefit unlimited for Number of Treatments? No Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is your Acupuncture benefit combined with either

the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

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





Indicate number of trips for Plan Approved Health-

related Location:

Select Plan Approved Health-related Location Trips

periodicity:

Every year

Select Type of Transportation for Plan Approved

Health-related Location:

One-way

Select Mode of Transportation for Plan Approved

Health-related Location:

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

6

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

Is there an enrollee Copayment? No Is authorization required? No No

Is a referral required for Transportation Services? Notes:

Transportation to Plan-Approved Location provided

by contracted transportation provider, who will

verify remaining trip balance.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Nο

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

No Is there an enrollee Copayment?



Are there preferred vendors/manufacturers for

Yes

Durable Medical Equipment (DME)?

Yes

Is authorization required?

Notes: Pre-authorization by PCP (for corresponding

> services) is managed through Referral/Authorization Form.

SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

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

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

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

Is authorization required?

Yes





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

Is there a service-specific Maximum Enrollee Out
No

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Services as Yes

a supplemental benefit under Part C?

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

Select type of benefit for Three (3) Pint Deductible Mandatory

Waived:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Outpatient Blood Services?

No

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

Does the plan provide Transportation Services as a

supplemental benefit under Part C?

Plan Approved Health-related Location

Select type of benefit for Plan Approved Health-

related Location:

Select enhanced benefit:

Mandatory

Is this benefit unlimited for number of trips for Plan

Approved Health-related Location?

No

Yes



Contrato Número

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

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

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

Is authorization required? Yes
Is a referral required for Outpatient Diagnostic Yes

Procedures/Test/Lab Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes
Is a referral required for Outpatient Yes

Diagnostic/Therapeutic Radiological, and X-Ray

Services?

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

Is authorization required for Medicare-covered

Yes

Outpatient Hospital Services?

Is authorization required for Medicare-covered No

Observation Services?

Is a referral required for Medicare-covered Yes

Outpatient Hospital Services?

Is a referral required for Medicare-covered No

Observation Services?

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

of focket cost.

Is there an enrollee Coinsurance?

SECTION B: #9B ASC SERVICES - BASE 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No

No

Is authorization required?

Yes

Is a referral required for Ambulatory Surgical

Yes

Center Services?





Notes: Preauthorization required through MCS Solutions.

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment? No

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

Is authorization required? Yes
Is a referral required for Physical Therapy and Yes

Speech-Language Pathology Services?



Yes

Do you offer an Additional Telehealth benefit for

Part B services?

Select the Medicare-covered benefits that may have

Additional Telehealth Benefits available:

: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1:

Individual Sessions for Psychiatric Services: 14e2:

Diabetes Self-Management Training

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Additional Telehealth?

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

No

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

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

Is authorization required for Additional Telehealth

Services?

Is a referral required for Additional Telehealth

Services?

No

No

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Copayment? No

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

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

Services?

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

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

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

Is there an enrollee Coinsurance?

No





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

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

	SECTION B	: #7E MENTAI	L HEALTH SPECIAL	TY	SERVICES - BASE 2
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Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes
Is a referral required for Mental Health Specialty No

Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

No

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? No
Is a referral required for Other Health Care Yes

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Outof-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

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



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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as a

supplemental benefit under Part C?

Yes

No

No

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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: 6

Select Routine Care periodicity: Every year

Is your Chiropractor Services benefit combined with either the Acupuncture or Alternative

Therapies benefit, or both?

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?



SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No
Is a referral required for Chiropractic Services?

Yes

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

Is authorization required? Yes
Is a referral required for Occupational Therapy Yes

Services?

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

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

Is authorization required? No
Is a referral required for Physician Specialist Yes

Services?



Does the plan provide Worldwide

Emergency/Urgent Coverage as a supplemental

benefit under Part C?

Select enhanced benefit: : Worldwide Emergency Coverage: Worldwide

Urgent Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage amount

for Worldwide Emergency/Urgent Coverage?

No

No

Yes

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

No

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

Notes: Coverage is managed through reimbursement based

on different fee schedules allowed by our plan, less

applicable member cost share.

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 1

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services

SECTION B: #6 HOME HEALTH SERVICES - BASE 1

Is there a service-specific Maximum Enrollee Out-

No

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #6 HOME HEALTH SERVICES - BASE 2

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

SECTION B: #6 HOME HEALTH SERVICES - BASE 3

Is authorization required? Yes
Is a referral required for Home Health Services? Yes

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?





Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

No

Zero

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care? Is there an enrollee Coinsurance?

No

No

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

Nο

SECTION B: #2 SNF - BASE 10

What is your SNF benefit period? Original Medicare

Is authorization required? Yes Yes Is a referral required for SNF Services?

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

Does the plan provide Cardiac and Pulmonary No

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Is a referral required for Cardiac and Pulmonary

Rehabilitation Services?

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

No

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

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SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 1 Does the plan provide Inpatient Hospital-Acute No Services as a supplemental benefit under Part C? **SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 2** Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? No Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? Is there an enrollee Coinsurance? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 7 Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #1A INPATIENT HOSPITAL-ACUTE - BASE 12 What is your Inpatient Hospital-Acute benefit Original Medicare period? Yes Is authorization required? Is a referral required for Inpatient Hospital-Acute Yes Services? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1 Does the plan provide Inpatient Hospital Psychiatric No Services as a supplemental benefit under Part C? Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 2 Does this plan's Medicare-covered benefit cost No sharing vary by hospital(s) in which an enrollee obtains care? Is there an enrollee Coinsurance? No SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 7 Is there an enrollee Deductible? No No Is there an enrollee Copayment? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 12 Contrato Número What is your Inpatient Hospital Psychiatric benefit Original Medicare period? Is authorization required? Yes

Is a referral required for Inpatient Psychiatric

Hospital Services?

Notes:

No

Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital stay

prior to SNF admission?

No

Yes



Physician Website Address:	www.mcsclassicare.com					
Customer Service Contact Phone Number for Current Medicare Beneficiaries:	(866)627-8183					
Customer Service Contact Local Phone Number for Current Medicare Beneficiaries:	(787)620-2530					
Customer Service Contact Phone Number for Prospective Medicare Beneficiaries:	(866)627-8181					
Customer Service Contact Local Phone Number for Prospective Medicare Beneficiaries:	(787)620-2528					
Customer Service Contact Phone Number for Current Part D Medicare Beneficiaries:	(866)627-8183					
Customer Service Contact Local Phone Number for Current Part D Medicare Beneficiaries:	(787)620-2530					
Customer Service Contact Phone Number for Prospective Part D Medicare Beneficiaries:	(866)627-8181					
SECTION A	: SECTION A-4					
Customer Service Contact Local Phone Number for Prospective Part D Medicare Beneficiaries:	(787)620-2528					
Customer Service Contact TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact Local TTY/TDD for Current Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact Local TTY/TDD for Prospective Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact Local TTY/TDD for Current Part D Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182					
Customer Service Contact Local TTY/TDD for Prospective Part D Medicare Beneficiaries:	(866)627-8182					
SECTION A: SECTION A-5						
Is your organization filing a standard bid for Section B of the PBP?	No					
Is your organization filing a standard bid for Section C of the PBP?	No					
SECTION A: SECTION A-6						



Is your organization filing a standard bid for Section D of the PBP?

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





40570 - Quebradillas, PR Service Area(s): 40580 - Rincon, PR Service Area(s): Service Area(s): 40590 - Rio Grande, PR Service Area(s): 40610 - Sabana Grande, PR 40620 - Salinas, PR Service Area(s): Service Area(s): 40630 - San German, PR Service Area(s): 40640 - San Juan, PR Service Area(s): 40650 - San Lorenzo, PR Service Area(s): 40660 - San Sebastian, PR Service Area(s): 40670 - Santa Isabel, PR Service Area(s): 40680 - Toa Alta, PR Service Area(s): 40690 - Toa Baja, PR Service Area(s): 40700 - Trujillo Alto, PR Service Area(s): 40710 - Utuado, PR 40720 - Vega Alta, PR Service Area(s): Service Area(s): 40730 - Vega Baja, PR 40740 - Vieques, PR Service Area(s): Service Area(s): 40750 - Villalba, PR 40760 - Yabucoa, PR Service Area(s): Service Area(s): 40770 - Yauco, PR Contract Number: H5577 029 Plan ID: 0 Segment ID: Contract Period: 2021 Puerto Rico Plan Geographic Name: Is this an Employer-Only plan? No

SECTION A: SECTION A-2

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No

Yes

Indicate CY2021 total projected member months for

this plan:

Does this Plan have a CMS-approved Continuation

Area?

Do you intend to participate in the PLATINO

program?

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

Is this D-SNP plan a Medicare zero-dollar cost sharing plan (this does not apply to Part D

Services)?

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees

in your D-SNP?

Yes

No

SECTION A: SECTION A-3

Participating Pharmacy Website Address: www.mcsclassicare.com
Formulary Website Address: www.mcsclassicare.com



Service Area(s):	40160 - Catano, PR
Service Area(s):	40170 - Cayey, PR
Service Area(s):	40180 - Ceiba, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40200 - Cidra, PR
Service Area(s):	40210 - Coamo, PR
Service Area(s):	40220 - Comerio, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40240 - Culebra, PR
Service Area(s):	40250 - Dorado, PR
Service Area(s):	40260 - Fajardo, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40280 - Guayama, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40300 - Guaynabo, PR
Service Area(s):	40310 - Gurabo, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40340 - Humacao, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40380 - Juncos, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40420 - Las Piedras, PR
Service Area(s):	40430 - Loiza, PR
Service Area(s):	40440 - Luquillo, PR
Service Area(s):	40450 - Manati, PR
Service Area(s):	40460 - Maricao, PR
Service Area(s):	40470 - Maunabo, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40510 - Naguabo, PR
Service Area(s):	40520 - Naranjito, PR
Service Area(s):	40530 - Orocovis, PR
Service Area(s):	40540 - Patillas, PR
Service Area(s):	40550 - Penuelas, PR
Service Area(s):	40560 - Ponce, PR



Completed Section B5 Status Section B6 Status Completed Section B7 Status Completed Section B8 Status Completed Section B9 Status Completed Section B10 Status Completed Section B11 Status Completed Section B12 Status Completed Section B13 Status Completed Section B14 Status Completed Section B15 Status Completed Section B16 Status Completed Section B17 Status Completed Section B18 Status Completed Section B19 Status Completed Section C Status Completed Section D Status Completed Section Mrx Status Completed

SECTION A: SECTION A-1

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Organization Web Site: www.mcsclassicare.com

MCS Classicare Platino MÃ; sCa\$h (HMO D-SNP) Plan Name:

Organization Type: Local CCP

HMO Plan Type:

Service Area(s):

Part A and Part B Enrollee Type:

Service Area(s): 40010 - Adjuntas, PR

40020 - Aguada, PR Service Area(s):

Service Area(s): 40030 - Aguadilla, PR

Service Area(s): 40040 - Aguas Buenas, PR

40050 - Aibonito, PR Service Area(s):

40060 - Anasco, PR Service Area(s):

40070 - Arecibo, PR Service Area(s):

Service Area(s): 40080 - Arroyo, PR

40090 - Barceloneta, PR Service Area(s):

Service Area(s): 40100 - Barranquitas, PR

40110 - Bayamon, PR

Service Area(s): 40120 - Cabo Rojo, PR

Service Area(s): 40130 - Caguas, PR Service Area(s): 40140 - Camuy, PR

Service Area(s): 40145 - Canovanas, PR

40150 - Carolina, PR Service Area(s):





Enter number of days for Standard Retail Cost

Sharing 3-month supply:

: Out-of-Network Pharmacy - one month supply

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

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

Enter number of days for Standard Mail-Order Cost

Sharing 3-month supply:

Select the Long-Term Care Pharmacy one month

Location/supply amount(s) that apply:

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

Are all of the drugs on your formulary available

with an extended day supply?

Are any of the drugs available at an extended day

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

30

90

: Standard Mail-Order - 3-month supply

90

: Long-Term Care Pharmacy - 1-month supply

31

No

Yes

SECTION RX: MEDICARE RX - NOTES

Notes: The PBP will implement a Part D RI program in

accordance with any final Application Proposal

approved by CMMI.

DATA REPORT FOR Contract H5577, PLAN 029, SEGMENT 0

Module: **PBP**

Requested By: d3ua

PLAN SYSTEM INFORMATION

Last entry Date: 05/29/2020 PBP Software Version: 2021.01

Plan Ready for Upload Timestamp: 05/29/2020 03:13:54 PM SA Western Standard

Time

05/30/2020 04:44:54 PM SA Western Standard MA BPT Timestamp:

Time

PD BPT Timestamp: 05/30/2020 04:44:55 PM SA Western Standard

Time

05/30/2020 04:49:39 PM SA Western Standard Last Upload File Creation Timestamp:

Time

Upload Status: 05/30/2020 #01806

PLAN STATUS

Plan Ready for Upload Section A Status

Section B1 Status Completed Section B2 Status Completed Section B3 Status Completed Section B4 Status Completed



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- 0.0

Indicate In-Network Maximum Enrollee Out-of-

Pocket Cost Amount:

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicare-

covered plan services?

Yes

3400.00

SECTION D: MAX PLAN BENEFIT COVERAGE

Is there a Maximum Plan Benefit Coverage

No

Amount?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits with

uniform cost sharing?

No

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Yes

Select the type of drug benefit:

Describe the components of your pharmacy network

(select all that apply):

: Standard Retail: Out-of-Network: Standard Mail-

Order: Long-Term Care

Defined Standard

Sponsor attests that it will comply with 42 CFR

423.154.

: Sponsor attests that it will comply with 42 CFR

423,154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

Does plan utilize ceiling pricing?

Are there quantity limits on certain prescription

drugs?

No No

Yes

Is prior authorization required for certain

prescription drugs?

Yes

No

Will your plan be limiting on-formulary coverage of

drugs to certain indications (i.e., are you

implementing indication-based formulary design)?

Do any drugs in your formulary require a step

therapy plan?

Yes

Do you pay for over-the-counter medications

(OTCs) under the utilization management program?

No

SECTION RX: DEFINED STANDARD - LOCATIONS AND LOCATION SUPPLY

Select all Standard Retail Cost sharing

Location/supply amount(s) that apply:

: Standard Retail Cost Sharing - 1 month Supply: Standard Retail Cost Sharing - 2 month Supply:

Standard Retail Cost Sharing - 3 month Supply

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

30

60







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Is authorization required? No
Is a referral required for Transportation for Non-No

Medical Needs?

Notes: Fleet includes 4-door sedans, minivans, buses with

hydraulic ramps. The total number of trips is for a combination of two benefits: -10b - Transportation Services for Health Related Needs, and -19b - #13i -

Transportation for Non-Medical Needs, if the

beneficiary qualifies for SSBCI.

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

#1

Yes

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Mandatory

Select type of benefit for General Supports for

Living:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

#1

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?

SECTION B: VBID/UF/SSBCI 19B #13I GENERAL SUPPORTS FOR LIVING - BASE 3: PACKAGE #1

Notes: General Supports for Living contains two separate

benefits: (1) Home Assistance - Eight (8) visits per

year (two per quarter) for Home Assistance

(Plumbing, Electricity, Locksmith) and categories

listed under Pest Control. (2) Subsidy for Electricity/Water/Telephone/Internet/Gas

SECTION C: V/T - GENERAL - US

Do you offer a US Visitor/Travel Program?

SECTION D: PLAN DEDUCTIBLE (IN-NETWORK)

No

No

Is there an In-Network Plan Deductible?

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

Is there an In-Network Maximum Enrollee Out-of-

Pocket Cost?

Yes

Is your In-Network Maximum Enrollee Out-of-

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

1 51

Voluntary



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Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 2: PACKAGE #1

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Pest Control?

No

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 3: PACKAGE #1

Notes: Services listed in this category will be combined

with those filed under SSBCI Category "General Supports for Living". Member will choose up to Two (2) Services per quarter from the following

options: - Pest Control - Preventive home

cleaning/disinfection - Any of the services listed under "Home Assistance" (filed under "General

Supports for Living")

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

Yes

No

Does the plan provide Transportation for Non-

Medical Needs as a supplemental benefit under Part

 \mathbb{C} ?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Location: Mandatory

Is this benefit unlimited for number of trips for

Plan-approved Location?

Indicate number of trips for Plan-approved 0

Location:

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

Needs for Plan-approved Location:

Select Mode of Transportation for Non-Medical : Me

Need for Plan-approved Location:

: Medical Transport: Other, Describe

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

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

SECTION B: VBID/UF/SSBCI 19B #13I TRANSPORTATION FOR NON-MEDICAL NEEDS - BASE 3: PACKAGE #1

Is there an enrollee Copayment?

No

No



Are any benefits exempt from the plan-level

No

deductible?

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

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? Yes Specify the maximum benefit amount: 60.00

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

Notes:

The following SSBCI benefits will be offered: -Food and Produce - Subsidy for Groceries - Pest Control - Transportation for Non-Medical Needs -General Supports for Living: (1) Home Assistance Services (2) Subsidy for Electricity, Water, Phone,

Internet, Gas Maximum benefit coverage

periodicity is every three months. Maximum benefit amount is for the combination of two benefits, "Food and Produce" and "Subsidy for Electricity, Water, Phone, Internet, Gas". Amount does not roll over/accumulate from one period to the next.

Maximum benefit amount does not apply to "Home

Assistance Services".

SECTION B: VBID/UF/SSBCI 19B #13I NON-PRIMARILY HEALTH RELATED BENEFITS FOR THE CHRONICALLY ILL - TYPE: PACKAGE #1

Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:

: Food and Produce: Pest Control: Transportation for Non-Medical Needs: General Supports for

Living

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

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

No

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

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

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

SECTION B: VBID/UF/SSBCI 19B #13I FOOD AND PRODUCE - BASE 3: PACKAGE #1

Notes: Food and Produce is a subsidy for groceries.

SECTION B: VBID/UF/SSBCI 19B #13I PEST CONTROL - BASE 1: PACKAGE #1

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

Yes

Select type of benefit for Pest Control:

Mandatory



Contrato Número



SECTION B: #18B HEARING AIDS - BASE 2

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

Plan-specified amount per period

Select the Maximum Plan Benefit Coverage type: Indicate Maximum Plan Benefit Coverage amount:

2500.00

Indicate Maximum Plan Benefit Coverage

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-

Nο

of-Pocket Cost?

Is there an enrollee Coinsurance?

No **SECTION B: #18B HEARING AIDS - BASE 4**

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

SECTION B: #18B HEARING AIDS - BASE 5

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

Notes: Benefit and Maximum Plan Coverage Amount

includes benefit for repair of devices.

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

No

Does your plan include MA Uniformity Flexibility

with reductions in cost or additional benefits?

Do you offer Special Supplemental Benefits for the Yes

Chronically Ill?

Select what type of benefit your SSBCI includes: : Additional Benefits

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

Yes

Does your VBID/MA Uniformity Flexibility/SSBCI

benefit offer additional Part C benefits?

How many packages do your Additional Benefits 1

contain? (1-15)

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

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

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

No

Is there a prerequisite for any additional benefits for

this package?

Select all the Non-Medicare-covered additional

: 13i: Non-Primarily Health Related Benefits for the

Centrato Número

benefits offered in this package: Chronically Ill

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No
Is a referral required for Eyewear? No

Notes: Eyewear benefit maximum amount includes repair

of eyewear. Provider and/or member must verify remaining combined maximum plan benefit

coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Yes

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams: Fitting/Evaluation for

Hearing Aid

Select type of benefit for Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

Mandatory

No, indicate number

Exams?

Indicate number for Routine Hearing Exams:

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

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for Hearing

Aid:

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there an enrollee Deductible?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

No

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

SECTION B: #18B HEARING AIDS - BASE 1

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

No, indicate number

types)?

Indicate quantity for Hearing Aids (all types):

2

Select Hearing Aids (all types) periodicity:

Every year





Is there a service-specific Maximum Plan Benefit

Coverage amount?

No

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? No Is a referral required for Eye Exams? No

SECTION B: #17B EYEWEAR - BASE 1

Yes

Does the plan provide Eyewear as a supplemental

benefit under Part C?

Select enhanced benefits: : Contact lenses: Eyeglasses (lenses and frames):

Eyeglass lenses: Eyeglass frames

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

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit Yes

Coverage amount?

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

Do you offer a Combined Max Plan Benefit Yes

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit 300.00

Coverage amount:

Select the Combined Maximum Plan Benefit Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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

No



Indicate Maximum Coinsurance percentage for Restorative Services:	30%
Indicate Minimum Coinsurance percentage for Endodontics:	30%
Indicate Maximum Coinsurance percentage for Endodontics:	30%
Indicate Minimum Coinsurance percentage for Periodontics:	30%
Indicate Maximum Coinsurance percentage for Periodontics:	30%
Indicate Minimum Coinsurance percentage for Extractions:	30%
Indicate Maximum Coinsurance percentage for Extractions:	30%
Indicate Minimum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	0%
Indicate Maximum Coinsurance percentage for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	30%
Is there an enrollee Deductible?	No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Is a referral required for Comprehensive Dental

Yes No

Services?

Notes: Coverage for crowns included under "Other

> Services". Minimum coinsurance applies to Oral Surgery. Maximum coinsurance applies to Prosthodontics and crowns. The replacement of a removable dental prosthesis will be covered five years after its initial insertion. The member who does not comply with the stated five-year term from the initial insertion, may use the Maximum Plan Benefit Coverage amount for services related to

his/her removable prosthesis.

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a supplemental

benefit under Part C?

Yes

1

Select enhanced benefit:

: Routine Eye Exams

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:

Every year

Select the Routine Eye Exams periodicity:



Is this benefit unlimited for Restorative Services? No, indicate number

Indicate number of visits for Restorative Services:

Every three years Select the Restorative Services periodicity:

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Select type of benefit for Endodontics: Mandatory

Is this benefit unlimited for Endodontics? Yes

Select type of benefit for Periodontics: Mandatory

Is this benefit unlimited for Periodontics? Yes

Select type of benefit for Extractions: Mandatory

Is this benefit unlimited for Extractions? Yes

Select type of benefit for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services:

Is this benefit unlimited for Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services?

Mandatory

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage 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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

Select which Comprehensive Dental Services have

a Coinsurance (Select all that apply):

: Medicare-covered Benefits: Non-routine Services:

Diagnostic Services: Restorative Services: Endodontics: Periodontics: Extractions:

Prosthodontics, Other Oral/Maxillofacial Surgery,

Other Services

Indicate the Minimum Coinsurance percentage for

Medicare-covered Benefits:

Indicate the Maximum Coinsurance percentage for

Medicare-covered Benefits:

Indicate Minimum Coinsurance percentage for 30%

Non-routine Services:

Indicate Maximum Coinsurance percentage for

Non-routine Services:

Indicate Minimum Coinsurance percentage for 30%

Diagnostic Services:

Indicate Maximum Coinsurance percentage for

Diagnostic Services:

Indicate Minimum Coinsurance percentage for

Restorative Services:

30%

30%

30%



30%

30%

Is there an enrollee Copayment? No Is authorization required for Medicare-covered No Glaucoma Screening? Is authorization required for Medicare-covered No Diabetes Self-Management Training? Is authorization required for Medicare-covered No **Barium Enemas?** Is authorization required for Medicare-covered No Digital Rectal Exams? Is authorization required for Medicare-covered No EKG following Welcome Visit? Is authorization required for Other Medicare-No covered Preventive Services?

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4

Is a referral required for any Services? No

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

Is there a Maximum Enrollee Out-of-Pocket Cost? No Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No Is there an enrollee Deductible? No Is Authorization Required? Yes Does the plan offer step therapy? Yes

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

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

No

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory

supplemental benefit?

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Yes

Does the plan provide Comprehensive Dental Items

as a supplemental benefit under Part C?

The residence

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:

Select the Diagnostic Services periodicity: Every six months

Mandatory Select type of benefit for Restorative Services:





Health Education Notes: Route to Wellness - Health and preventive

> workshops, preventive care reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. MCS En Alerta -Guidance on preventive measures and actions to take in case of natural disasters and to reduce health

complications.

Nutritional/Dietary Benefit Notes: Personal evaluation and diet plan designed by

licensed dietitian according to patient's health

needs, including exercise suggestions.

Route to Wellness - Exercise and Nutrition Fitness Benefit Notes:*

> Education Interventions. Member has access to fitness classes to promote physical activity and a

healthier lifestyle.

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

Remote Access Technology (Web/Phone-based technologies) Notes:*

Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as

allergies, flu, among others.

Remote Access Technologies (Nursing Hotline)

MCS Medil Anea-Nursing Hotline.

Notes:

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

Alternative Therapies Notes:*

Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical

professional.

Therapeutic Massage Notes:*

Therapeutic massage is limited to six (6) visits per year and must be ordered by a physician or medical

professional.

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

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Kidney Disease Education

No

Services?

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

Contrato Número

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost for Other Medicare-covered

Preventive Services?

No

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Alternative Therapies*: 14c18: Therapeutic

Massage* Mandatory

Mandatory

Select type of benefit for Health Education:

Select type of benefit for Nutritional/Dietary

Benefit:

Is this benefit unlimited for Nutritional/Dietary

Benefit?

Indicate number of visits for Nutritional/Dietary

Benefit:

Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

Select type of benefit for Remote Access

Technologies (including Web/Phone-based

technologies and Nursing Hotline):

Select the type of Remote Access Technologies

offered (Select all that apply):

No, indicate number

6

Individual Sessions

Mandatory

: Physical Fitness

Mandatory

: Web/Phone-based technologies: Nursing Hotline

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

Select type of benefit for Alternative Therapies: Mandatory

No, indicate number Is this benefit unlimited for Alternative Therapies?

Indicate number of visits offered for Alternative

Therapies:

Is your Alternative Therapies benefit combined with

either the Chiropractor Services benefit or

Acupuncture benefit, or both?

Select type of benefit for Therapeutic Massage:

No

6

Mandatory

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

No

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 6

No

Is there a service-specific Maximum Enrollee Outof-Pocket Cost for Other Defined Supplemental

Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 9

Is there an enrollee Coinsurance? No

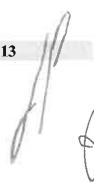
SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 11

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

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 13

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

Supplemental Benefits?



POS DE

Is a referral required for Acupuncture?

Nο

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter (OTC)

Items as a supplemental benefit under Part C?

Select type of benefit for OTC Items:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Indicate Maximum Plan Benefit Coverage amount: 40.00

Select Maximum Plan Benefit Coverage

periodicity:

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

unused?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Are you offering Nicotine Replacement Therapy

(NRT) as a Part C OTC benefit?

Yes

Mandatory

Yes

Every three months

No

No No

SECTION B: #13B OTC ITEMS - BASE 2

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

SECTION B: #13C MEAL BENEFIT - BASE 1

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

No

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

Medicare-covered Zero Dollar Preventive Services

Attestation

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

Is authorization required? No Is a referral required? Nο

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

Does the plan provide the Annual Physical Exam as

a supplemental benefit under Part C?

No

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

Does the plan provide Other Defined Supplemental

Benefits as a benefit under Part C?

Yes

: 14c1: Health Education: 14c2: Nutritional/Dietar Select enhanced benefit (Select all that apply):

Benefit: 14c4: Fitness Benefit*: 14c7: Remote Access Technologies (including Web/Phone-based

technologies and Nursing Hotline)*: 14c17:

Centrate Número

Notes: Pre-authorization by PCP (for corresponding

services) is managed through Referral/Authorization Form.

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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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

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

Is there an enrollee Copayment? No

Do you limit Diabetic Supplies and Services to Yes

those from specified manufacturers?

Is authorization required? Yes

Notes: Pre-authorization by PCP (for corresponding

services) is managed through Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #12 DIALYSIS SERVICES - BASE 2

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

SECTION B: #13A ACUPUNCTURE - BASE 1

Yes

No

No

No

Does the plan provide Acupuncture as a

supplemental benefit under Part C?

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: 6

Indicate Number of Treatments periodicity: Every year

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is your Acupuncture benefit combined with either

the Chiropractor Services benefit or Alternative

Therapies benefit, or both?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No

