MEDICARE PLATINO CONTRACT

APPENDIX C (1) (22)

MEDICARE ADVANTAGE PRODUCT PLAN BENEFITS PACKAGE (PBP)



MCS ADVANTAGE, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5577-002



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 002, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

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

Plan Ready for Upload Timestamp: 06/06/2021 06:25:13 PM SA Western Standard

Time

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Time

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Time

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Time

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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. 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: **HMO** Enrollee Type: Part A and Part B Service Area(s): 40010 - Adjuntas, PR 40020 - Aguada, PR Service Area(s): 40030 - Aguadilla, PR Service Area(s): 40040 - Aguas Buenas, PR Service Area(s): Service Area(s): 40050 - Aibonito, PR Service Area(s): 40060 - Anasco, PR Service Area(s): 40070 - Arecibo, PR 40080 - Arroyo, PR Service Area(s): Service Area(s): 40090 - Barceloneta, PR 40100 - Barranguitas, PR Service Area(s): Service Area(s): 40110 - Bayamon, PR 40120 - Cabo Rojo, PR Service Area(s): Service Area(s): 40130 - Caguas, PR 40140 - Camuy, PR Service Area(s): Service Area(s): 40145 - Canovanas, PR 40150 - Carolina, PR Service Area(s): Service Area(s): 40160 - Catano, PR 40170 - Cayey, PR Service Area(s): Service Area(s): 40180 - Ceiba, PR Service Area(s): 40190 - Ciales, PR Service Area(s): 40200 - Cidra, PR 40210 - Coamo, PR Service Area(s): SHINISTRACION OF Service Area(s): 40220 - Comerio, PR Service Area(s): 40230 - Corozal, PR Service Area(s): 40240 - Culebra, PR Contrato Número Service Area(s): 40250 - Dorado, PR 22 -0.0Service Area(s): 40260 - Fajardo, PR G MOUPOS DES 40265 - Florida, PR Service Area(s): Service Area(s): 40270 - Guanica, PR 40280 - Guayama, PR Service Area(s): 40290 - Guayanilla, PR Service Area(s): Service Area(s): 40300 - Guaynabo, PR 40310 - Gurabo, PR Service Area(s):

40320 - Hatillo, PR

40330 - Hormigueros, PR

Service Area(s):

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
	40540 TC DD

Service Area(s):

Service Area(s):

Service Area(s):

DMINISTRACION DE

Contrato Número
2 - 0 0 4

OF OS DE ST

40740 - Vieques, PR

40750 - Villalba, PR

40760 - Yabucoa, PR

Service Area(s): 40770 - Yauco, PR

Contract Number: H5577
Plan ID: 002
Segment ID: 0
Contract Period: 2022

Plan Geographic Name: Puerto Rico

Is this an Employer-Only plan?

SECTION A: SECTION A-2

Indicate CY2022 total projected member months

for this plan:

519875

Does this Plan have a CMS-approved Continuation

Area?

No

Do you intend to participate in the PLATINO

program?

Yes

Is this a Special Needs Plan? Yes

Special Needs Plan Type: Dual-Eligible

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

sharing plan (this does not apply to Part D

Services)?

No

Yes

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

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** 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?

No

SECTION A: SECTION A-6

No

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)

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

No

Does the plan provide Inpatient Hospital-Acute

Services as a supplemental benefit under Part C?

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

No

Is there a service-specific Maximum Enrollee Out-No

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 Is there an enrollee Copayment? No

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

What is your Inpatient Hospital-Acute benefit

period?

Original Medicare

Is authorization required? Yes

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 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

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.

SECTION B: #2 SNF - BASE 1

No

Yes

Zero

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

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

No

Does this plan's Medicare-covered benefit cost

sharing vary by the Skilled Nursing Facility in

which an enrollee obtains care?

Is there an enrollee Coinsurance?

SECTION B: #2 SNF - BASE 6

Is there an enrollee Copayment?

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 No Rehabilitation Services as a supplemental benefit under Part C?

De



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 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? 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 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 Select type of benefit for Worldwide Emergency OHINISTRACION D 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

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

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

of-Pocket Cost?

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-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 No Is there an enrollee Copayment? SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1 Does the plan provide Chiropractic Services as a Yes 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: Select Routine Care periodicity: Every year Is there a service-specific Maximum Plan Benefit No Coverage amount?

of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

No

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No
Is authorization required?

No

Is there a service-specific Maximum Enrollee Out-



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? 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? Nο 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? Preauthorization required through MCS Rook Notes: **SECTION B: #7F PODIATRY SERVICES - BASE 1** Does the plan provide Podiatry Services as a No Contrato Número supplemental benefit under Part C? -0.0Is there a service-specific Maximum Enrollee Out-No GUROS 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**

No

Is authorization required?

Is a referral required for Podiatrist Services?

Yes

No

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

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?

No

SECTION B: #7J 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

No

No

Is authorization required for Additional Telehealth

Services?

Is a referral required for Additional Telehealth

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 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? Nο

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

Is there a service-specific Maximum Enrollee Out-No

of-Pocket Cost?

Contrato Numero

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 No Is authorization required? Is a referral required for Outpatient Substance No Abuse? SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 1 Does the plan provide Outpatient Blood Services as Yes a supplemental benefit under Part C? Contrato Número : Three (3) Pint Deductible Waived

Select enhanced benefit:

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? No

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

No

No

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? No 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 Yes supplemental benefit under Part C? Select enhanced benefit: Plan Approved Health-related Location Select type of benefit for Plan Approved Health-Mandatory related Location: Is this benefit unlimited for number of trips for Plan No Approved Health-related Location? Indicate number of trips for Plan Approved Health-24 related Location: Select Plan Approved Health-related Location Trips Every year periodicity: Select Type of Transportation for Plan Approved One-way Health-related Location: Select Mode of Transportation for Plan Approved : Medical Transport Health-related Location: SECTION B: #10B TRANSPORTATION SERVICES - BASE 2 Is there a service-specific Maximum Plan Benefit No Contrato Número Coverage amount? 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: #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.



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)? Yes Is authorization required? 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? Is there an enrollee Coinsurance? No 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 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 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

No

Is authorization required?

Is a referral required for Dialysis Services?

No

SECTION B: #13A ACUPUNCTURE - BASE 1

Does the plan provide Acupuncture as a

Yes

supplemental benefit under Part C?

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of 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

No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

SECTION B: #13B OTC ITEMS - BASE 1
-Counter (OTC) No

No

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

Items as a supplemental benefit under Part C?

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.

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

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?

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:



Alternative Therapies*: 14c18: Therapeutic ONINISTRACION

Massage*

No, indicate number

: Physical Fitness

Select type of benefit for Health Education: Mandatory Mandatory

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: Individual Sessions

Select type of benefit for Fitness Benefit: Mandatory

Indicate type of Fitness Benefit offered (Select all

that apply):

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? No, indicate number

Indicate number of visits offered for Alternative 6

Therapies:

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

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No Indicate limit for number of sessions 6

Indicate the number of sessions periodicity: Every year

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

No

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

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

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 10

Is there an enrollee Coinsurance? No

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

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

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

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

Supplemental Benefits?

Health Education Notes: Health and preventive workshops, preventive care

reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. 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:* 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 15

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:

Nursing Hotline.

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

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 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 B.

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

Nο

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

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

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

Is there an enrollee Copayment? No

Is authorization required for Medicare-covered

Glaucoma Screening?

No

Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

No No

No

No

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?

-----**,**

Does the plan provide Preventive Dental Items as a

supplemental benefit under Part C?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Yes

SECTION B: #16A PREVENTIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Items

as a supplemental benefit under Part C?

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

Restorative Services: Endodontics: Periodontics:

Extractions: Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine 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: 1

Select the Restorative Services periodicity: Every three years

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

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22 - 004

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

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Indicate Maximum Plan Benefit Coverage amount: 2500.00
Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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 a referral required for Comprehensive Dental No

Services?

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? 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?

Is there a service-specific Maximum Enrollee Out-

- C D - -1--4 C - -40

of-Pocket Cost?

No

No

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No

No

No

No



SECTION B: #17A EYE EXAMS - BASE 3
Is authorization required?
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):

Is this benefit unlimited for Eyeglasses (lenses and

frames)?

Mandatory

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Yes

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

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Evewear?

Indicate Combined Maximum Plan Benefit 700.00

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

.

Every year

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No 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

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coverage amount available.

SECTION B: #18A HEARING EXAMS - BASE 1

Does the plan provide Hearing Exams as a

supplemental benefit under Part C?

Select enhanced benefits:

: Routine Hearing Exams: Fitting/Evaluation for

Hearing Aid Mandatory

Yes

Select type of benefit for Routine Hearing Exams:

Is this benefit unlimited for Routine Hearing

Exams?

No, indicate number

Indicate number for Routine Hearing Exams: 1

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

Hearing Aid:

Is this benefit unlimited for Fitting/Evaluation for

Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for Hearing 1

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 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? No

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

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): 2

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

Both ears combined

Yes

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: Plan-specified amount per period

2500.00 Indicate Maximum Plan Benefit Coverage amount:





Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

SECTION B: #18B HEARING AIDS - BASE 4

Is there an enrollee Copayment?

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

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

Are you offering a VBID Hospice Benefit?

No
Are you offering Part C benefits under the VBID

Yes

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

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition or Socioeconomic Status: Cash or Monetary Rebates

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Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Medicare Health Risk Assessment

WHP Mode of Engagement (choose one or more): : Telephonic: In-Person: Web-Based

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP

Services?

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

activities?

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

Expected Number of Beneficiaries to be Engaged Annually:

No

No

: Provider/Patient portals: Data Warehouse

SECTION B: #19 VBID - CASH OR MONETARY REBATES

19508

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

70.00 Cash or Monetary Rebates amount per month: Maximum Annual Cash or Monetary Rebates 840.00

available:

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

Does your VBID/MA Uniformity

Flexibility/SSBCI benefit offer Part C reductions in

cost?

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

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

1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

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

To which chronic condition does this benefit apply?

(Select all that apply):

: Chronic alcohol and other drug dependence:

Autoimmune disorders: Cancer: Cardiovascular

disorders: Chronic heart failure: Dementia:

Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS: Chronic lung disorders: Chro::::::

Chronic lung disorders

Crohn's disease or Ulcerative colitis Other 1 Description:

Other 2 Description: Anemia

Chronic obstructive pulmonary disease (COPD) Other 3 Description:

Other 4 Description: Severe mental retardation Other 5 Description: Moderate to Severe Autism

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

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?

benefits offered in this package:

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 - Home Assistance Services Maximum benefit coverage periodicity applies for Pest Control and General Supports for Living - every three months.

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:

: Pest Control: Transportation for Non-Medical

Needs: General Supports for Living

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?

Select type of benefit for Pest Control:

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 PEST CONTROL - 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 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 Three (3) 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

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Location:

Is this benefit unlimited for number of trips for

Plan-approved Location?

Indicate number of trips for Plan-approved

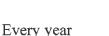
Location:

Select Plan-approved Location Trips periodicity:

Mandatory

No

0





Select Type of Transportation for Non-Medical

Needs for Plan-approved Location:

One-way

receds for real approved Ecodeton.

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

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 -

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Contrato Número

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?

Mandatory

No

No

Yes

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

No

Living?

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

#1

Notes: Home Assistance - Twelve (12) visits per year (three per quarter) for Home Assistance (Plumbing,

Electricity, Locksmith, Pet Grooming, Technology Assistance) 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-

Yes

Pocket Cost?

Is your In-Network Maximum Enrollee Out-of-

Voluntary

Pocket (MOOP) Cost at the Voluntary or

Mandatory Level?

3400.00

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 QUINISTRACION O

Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-

covered plan services?

Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Yes

Select the type of drug benefit:

Defined Standard

Describe the components of your pharmacy

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

network (select all that apply):

Order: Long-Term Care

Sponsor attests that it will comply with 42 CFR

423,154,

: Sponsor attests that it will comply with 42 CFR

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423.154.

SECTION RX: MEDICARE RX GENERAL 2

Does plan utilize floor pricing?

No

Does plan utilize ceiling pricing?

No

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

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:

30

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

60

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

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

Location/supply amount(s) that apply:

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 Mail-Order - 3-month supply

: Long-Term Care Pharmacy - 1-month supply

No Yes

31

90

SECTION RX: VBID - GENERAL

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



MCS ADVANTAGE, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5577-017



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: 06/06/2021 PBP Software Version: 2022.01

Plan Ready for Upload Timestamp: 06/06/2021 05:13:22 PM SA Western Standard Time MA BPT Timestamp: 06/07/2021 04:59:40 PM SA Western Standard Time PD BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time Last Upload File Creation Timestamp: 06/07/2021 05:13:57 PM SA Western Standard Time

Upload Status: 06/07/2021 #02307

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

Section B10 Status

Completed

Section B11 Status

Section B12 Status

Completed

Section B13 Status

Completed

Section B14 Status

Completed

Section B15 Status

Completed

Completed

Completed

Completed

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 Progreso (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 - Arroyo, 1 K
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
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:	017
Segment ID:	0



Contract Period: 2022

Plan Geographic Name: Puerto Rico

Is this an Employer-Only plan?

SECTION A: SECTION A-2

No

No

Yes

329349

Indicate CY2022 total projected member months

for this plan:

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

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 (787)620-2530

for Current Medicare Beneficiaries:

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

Prospective Medicare Beneficiaries:

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

for Prospective Medicare Beneficiaries:

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

Current Part D Medicare Beneficiaries:

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

for 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 (787)620-2528

for 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 No Section B of the PBP? Is your organization filing a standard bid for No Section C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for No Section 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** PAINISTRACION 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 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 Is a referral required for Inpatient Hospital-Acute Yes Services? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1 Does the plan provide Inpatient Hospital No

Psychiatric Services as a supplemental benefit

under Part C?



Is there a service-specific Maximum Enrollee 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? No

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?

Preauthorization required through MCS Solutions, Notes:

except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1

No

Zero

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part C?

Do you allow less than 3 day inpatient hospital Yes

stay 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-No

of-Pocket Cost?

SECTION B: #2 SNF - BASE 2

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? Nο

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?

No SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 3

No Is there an enrollee Deductible?

No Is there an enrollee Copayment?

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

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

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

Yes

Is there an enrollee Copayment? No

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

Mandatory

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-

of-Pocket Cost?

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

No

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

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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?

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?

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 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

No

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-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? 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? 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? Contrato Número No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #7F PODIATRY SERVICES - BASE 3**

No

Yes

Is authorization required?

Is a referral required for Podiatrist Services?

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 Nο 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? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? **SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3** 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 SMINISTRACION of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Contrato Número Is there an enrollee Copayment? Nο 22 -0.0SECTION B: #7I PT AND SP SERVICES - BASE 2 Yes Is authorization required? POSD 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 : 7a: Primary Care Physician Services: 7d: Physician have Additional Telehealth Benefits available: 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-No of-Pocket Cost for Additional Telehealth? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2

No

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment? 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? 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 No **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 Contrato Número Is there a service-specific Maximum Enrollee Out-No of-Pocket Cost?

No

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? 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 Yes as a supplemental benefit under Part C? Contrato Númer 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? No SECTION B: #9D OUTPATIENT BLOOD SERVICES - BASE 2

No

No

Is there an enrollee Deductible?

Is there an enrollee Copayment?

De

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

Services?

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 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

32

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

Mandatory

One-way

: Medical Transport

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

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: #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

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verify remaining trip balance.

SECTION B: #11A DME - 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: #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?

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

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?

Indicate limit for Number of Treatments: 6

Indicate Number of Treatments periodicity:

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

Every year

No No

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 Is a referral required for Acupuncture? No

SECTION B: #13B OTC ITEMS - BASE 1

No

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

Items as a supplemental benefit under Part C?

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?

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:







Alternative Therapies*: 14c18: Therapeutic

Massage*

No, indicate number

: Physical Fitness

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:

Individual Sessions Indicate setting for Nutritional/Dietary Benefit:

Select type of benefit for Fitness Benefit: Mandatory

Indicate type of Fitness Benefit offered (Select all

that apply):

Mandatory

6

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):

: Web/Phone-based technologies: Nursing Hotline

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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

6 Indicate number of visits offered for Alternative

Therapies:

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

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No 6 Indicate limit for number of sessions

Indicate the number of sessions periodicity: Every year

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4 No

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined Supplemental

Benefits?

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

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 10

No Is there an enrollee Coinsurance?

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

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

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

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

Supplemental Benefits?

Health Education Notes: Health and preventive workshops, preventive care

> reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. 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:* 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 15

Remote Access Technology (Web/Phone-based

technologies) Notes:*

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

among others. Nursing Hotline.

Remote Access Technologies (Nursing Hotline)

Notes:

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

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

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_ 0 0 4

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

Is authorization required? No

Is a referral required for Kidney Disease Education No

Services?

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

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered Glaucoma Screening?

Is authorization required for Medicare-covered No Diabetes Self-Management Training?

Is authorization required for Medicare-covered No Barium Enemas?

Is authorization required for Medicare-covered No Digital Rectal Exams?

Is authorization required for Medicare-covered No No Digital Rectal Exams?

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

Is a referral required for any Services?

EKG following Welcome Visit?

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

Does the plan provide Comprehensive Dental Yes

Items as a supplemental benefit under Part C?

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

Restorative Services: Endodontics: Periodontics:

Extractions: Prosthodontics, Other

Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine 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: 1

Select the Restorative Services periodicity: Every three years



SECTION B: #16B COMPREHENSIVE DENTAL - BASE 2

Mandatory

Yes

Yes

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?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Indicate Maximum Plan Benefit Coverage amount: 3000.00 Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

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 a referral required for Comprehensive Dental No

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

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 No

Coverage amount?

Is there a service-specific Maximum Enrollee Out- No

of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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



Is there an enrollee Deductible?

No

No

No

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required? Is a referral required for Eye Exams?

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

Mandatory Select type of benefit for Contact lenses:

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 Yes

frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

Select type of benefit for Eyeglass frames: Mandatory

Is this benefit unlimited for Eyeglass frames? Yes

SECTION B: #17B EYEWEAR - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Yes

Yes

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

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit 1000.00

Coverage amount:

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

Is there an enrollee Coinsurance?

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

Eyewear benefit maximum amount includes repair of Notes:

evewear. Provider and/or member must verify

remaining combined maximum plan benefit coverage

MINISTRAC/O

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:

Is this benefit unlimited for Routine Hearing

Exams?

Mandatory

No, indicate number

Indicate number for Routine Hearing Exams: 1

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

Coverage amount?

No

Is there an enrollee Deductible? No

Is there a service-specific Maximum Enrollee Out-

of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

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

2 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?

Yes

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears combined?

Both ears combined

Select the Maximum Plan Benefit Coverage type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage amount:

3000.00



Indicate Maximum Plan Benefit Coverage

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? Nο

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?

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

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

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

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

Value-Based Insurance Design Attestation : I attest that

WHP Program Type (choose one or more): : Medicare Health Risk Assessment

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

No

No

49323

WHP Mode of Engagement (choose one or more): : Telephonic: In-Person: Web-Based

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP

Services?

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

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

Expected Number of Beneficiaries to be Engaged Annually:

: Provider/Patient portals: Data Warehouses DE

: Value-Based Design Flexibilities by Condition or

Socioeconomic Status: Cash or Monetary Rebates

SECTION B: #19 VBID - CASH OR MONETARY REBATES

Type of Cash or Monetary Rebates: : Debit Card/Check Cash or Monetary Rebates amount per month: 70.00

Maximum Annual Cash or Monetary Rebates 840.00

available:

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C reductions

in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

How many packages do your Additional Benefits 1

contain? (1-15)

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

#1

Is this package applicable to VBID or MA

Uniformity Flexibility or SSBCI?

SSBCI

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

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence: Autoimmune disorders: Cancer: Cardiovascular

disorders: Chronic heart failure: Dementia: Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS: Chronic lung disorders: Chro: : : : : : Chronic lung

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disorders

Other 1 Description: Crohn's disease or Ulcerative colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive pulmonary disease (COPD)

Other 4 Description: Severe mental retardation
Other 5 Description: Moderate to Severe Autism

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?

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 - Home Assistance Services Maximum benefit coverage periodicity applies for Pest Control and General Supports for Living - every three months.

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

: Pest Control: Transportation for Non-Medical

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

supplemental benefit under Part C?

Yes

Select type of benefit for Pest Control:

Mandatory

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: 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 Three (3) 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-

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

Plan-approved Location?

Indicate number of trips for Plan-approved

Location:

Select Plan-approved Location Trips periodicity: Every year

Yes

No

0



Select Type of Transportation for Non-Medical

Needs for Plan-approved Location:

One-way

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

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: 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

#1

Does the plan provide General Supports for Living

as a supplemental benefit under Part C?

Living Yes

Select type of benefit for General Supports for

Living:

Mandatory

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

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

Notes: Home Assistance - Twelve (12) visits per year (three

per quarter) for Home Assistance (Plumbing,

Electricity, Locksmith, Pet Grooming, Technology Assistance) 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-

Yes

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:

3400.00

Voluntary

Select the benefits that apply to the In-Network

Maximum Enrollee Out-of-Pocket cost:

: In-Network Medicare-covered benefits OHINISTRACION

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-0.0

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicare-

covered plan services?

Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription drug

(Part D) benefit?

Yes

Defined Standard 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

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?

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:

30

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 90 Cost 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 No

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

with an extended day supply?

Yes

SECTION RX: VBID - GENERAL

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

No





MCS ADVANTAGE, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5577-029



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 029, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

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

Plan Ready for Upload Timestamp: 06/06/2021 05:13:46 PM SA Western Standard Time MA BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time PD BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time Last Upload File Creation Timestamp: 06/07/2021 05:13:57 PM SA Western Standard Time

Upload Status: 06/07/2021 #02307

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 A: SECTION A-1

Completed

Completed

Completed

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Section C Status

Section D Status

Section Mrx Status

Organization Web Site: www.mcsclassicare.com

Plan Name: MCS Classicare Platino MÃ; sCa\$h (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):	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
~	10570 - Juana Diaz, I K



Samina Amaga).	40290 I DD
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
Service Area(s):	40770 - Yauco, PR
Contract Number:	H5577
Plan ID:	029
A	02)

0

Segment ID:

Contrato Número

SDESA

Contract Period: 2022

Plan Geographic Name: Puerto Rico

Is this an Employer-Only plan?

SECTION A: SECTION A-2

92365

Indicate CY2022 total projected member months

for this plan:

Does this Plan have a CMS-approved No

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

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 (787)620-2530

for Current Medicare Beneficiaries:

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

Prospective Medicare Beneficiaries:

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

for Prospective Medicare Beneficiaries:

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

Current Part D Medicare Beneficiaries:

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

for 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 (787)620-2528

for 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 No Section B of the PBP? Is your organization filing a standard bid for No Section C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for No Section D of the PBP? Do any of your outpatient services have tiered No 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 No Out-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? DAINISTRACION 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 Services? SECTION B: #1B INPATIENT HOSPITAL PSYCHIATRIC - BASE 1 Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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? 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 Original Medicare

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.

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SECTION B: #2 SNF - BASE 1

Zero

No

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 Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee No

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? 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

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 No

Is there a service-specific Maximum Enrollee

Out-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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

SECTION B: #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

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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

No

Coverage?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance? No 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 No

Out-of-Pocket Cost?

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

SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2

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

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 No

Out-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 No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1
Chiropractic Services as a 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

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 there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No

Is authorization required?

No

Is a referral required for Chiropractic Services?

Yes





SECTION B: #7C OCCUPATIONAL THERAPY SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #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 No Out-of-Pocket Cost? SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7E MENTAL HEALTH SPECIALTY SERVICES - BASE 3 Is authorization required? 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 DAINISTRAC/OZ supplemental benefit under Part C? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #7F PODIATRY SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #7F PODIATRY SERVICES - BASE 3** Is authorization required? No Is a referral required for Podiatrist Services? Yes

SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7G OTHER HEALTH CARE PROFESSIONAL - BASE 2 Is authorization required? No Is a referral required for Other Health Care Yes Professional Services? **SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? **SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2** Is there an enrollee Coinsurance? 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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #7I PT AND SP SERVICES - BASE 2 Is authorization required? Yes Is a referral required for Physical Therapy and CAOSDE 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 : 7a: Primary Care Physician Services: 7d: Physician have Additional Telehealth Benefits available: 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 No Out-of-Pocket Cost for Additional Telehealth? SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No

Is there an enrollee Copayment? No SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3 Is authorization required for Additional No Telehealth Services? Is a referral required for Additional Telehealth No Services? SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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 No **Program Services?** SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee Coinsurance? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 Is there an enrollee Deductible? Nο 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 No Out-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 3TRACION SECTION B: #8B OUTPATIENT DIAG/THERAPEUTIC RAD SERVICES - BA Is authorization required? Yes Is a referral required for Outpatient Yes Contrato Número Diagnostic/Therapeutic Radiological, and X-Ray Services? SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1 POSDE Is there a service-specific Maximum Enrollee No

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #9A OUTPATI	ENT HOSPITAL SERVICES - BASE 2
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No
SECTION B: #9B	ASC SERVICES - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
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 Center Services?	Yes
SECTION B: #9C OUTPATI	ENT SUBSTANCE ABUSE - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #9C OUTPATI	ENT 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 OUTPATI	ENT SUBSTANCE ABUSE - BASE 3
Is authorization required?	No No
Is a referral required for Outpatient Substance Abuse?	No No No Contrato Número
SECTION B: #9D OUTPAT	IENT BLOOD SERVICES - BASE 1 6 - 0 0 4
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes CLAOS DE SAY
Select enhanced benefit:	: Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
SECTION B: #9D OUTPAT	IENT 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 No Services?

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1 Yes

No

10

Yes

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

Mandatory

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? Nο

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

AINISTRAC/C

remaining trip balance.

SECTION B: #11A DME - BASE 1

Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #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 No Out-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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE/2 Contrato Número 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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #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

supplemental benefit under Part C?

Yes

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Treatments:

Mandatory

Is this benefit unlimited for Number of

No

Treatments?

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

No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Acupuncture?

No

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SECTION B: #13B OTC ITEMS - BASE 1

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

No

Items as a supplemental benefit under Part C?

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

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*

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary

Benefit:

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

Mandatory

Mandatory

Mandatory

Select type of benefit for Fitness Benefit:

Indicate type of Fitness Benefit offered (Select all

that apply):

: Physical Fitness

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):

: Web/Phone-based technologies: Nursing Hotline

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

Select type of benefit for Alternative Therapies:

Is this benefit unlimited for Alternative

No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

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

6

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No Indicate limit for number of sessions 6

Indicate the number of sessions periodicity: Every year

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

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined

Supplemental Benefits?

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 7 No

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance? No

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

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

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

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

Supplemental Benefits?

Health Education Notes: Health and preventive workshops, preventive care

reminders, and self-care guides. Healthy Welcome

Program - Coordination of initial healthy welcome visit. 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:*

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 15

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

Video doctor visits are intended to complement faceto-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:

Nursing Hotline.

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

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 2

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-covered

Preventive Services?

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

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

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICE

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

Glaucoma Screening?

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Is authorization required for Medicare-covered

Diabetes Self-Management Training?

Is authorization required for Medicare-covered

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

No

No

No

No

SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 4 No

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

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 No

Does the plan provide Preventive Dental Items as

a 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?

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

> Restorative Services: Endodontics: Periodontics: Extractions: Prosthodontics, Other Oral/Maxillofacial

> > POSDES

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

No, indicate number Is this benefit unlimited for Restorative Services?

Indicate number of visits for Restorative Services: 1

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:

Mandatory

Is this benefit unlimited for Prosthodontics, Other Yes

Oral/Maxillofacial Surgery, Other Services?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Indicate Maximum Plan Benefit Coverage 2000.00

amount:

Select the Maximum Plan Benefit Coverage Every year

periodicity:

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment? No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required? Yes No

Is a referral required for Comprehensive Dental

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a Yes

supplemental benefit under Part C?

Select enhanced benefit: : Routine Eye Exams

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?

No

1

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

SECTION B: #17A EYE EXAMS - BASE 2

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

benefit under Part C?

Select enhanced benefits:

Yes

: 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** 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?

Yes

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

Is authorization required? No 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

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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:

Is this benefit unlimited for Routine Hearing

Exams?

Mandatory

No, indicate number

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?

Indicate number for Fitting/Evaluation for

Hearing Aid:

Select Fitting/Evaluation for Hearing Aid Every year

periodicity:

No, indicate number

SECTION B: #18A HEARING EXAMS - BASE 2
eximum Plan Benefit No

1

Is there a service-specific Maximum Plan Benefit

Coverage amount?

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

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #18A HEARING EXAMS - BASE 3

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

SECTION B: #18B HEARING AIDS - BASE 1

Does the plan provide Hearing Aids as a Yes

supplemental benefit under Part C?

Select enhanced benefits: : Hearing Aids (all types)

Select type of benefit for Hearing Aids (all 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 Plan Benefit

Coverage amount?

Yes

Both ears combined

Does the Maximum Plan Benefit Coverage

Amount apply per ear or for both ears combined?

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

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Indicate Maximum Plan Benefit Coverage

amount:

1000.00

Indicate Maximum Plan Benefit Coverage

Every year

periodicity:

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No **SECTION B: #18B HEARING AIDS - BASE 4**

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

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

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

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

In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition or Socioeconomic Status: Cash or Monetary Rebates

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Medicare Health Risk Assessment

WHP Mode of Engagement (choose one or more): : Telephonic: In-Person: Web-Based

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP

Services?

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

No

5851

No

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points

Expected Number of Beneficiaries to be Engaged

Annually:

: Provider/Patient portals: Data Warehouses



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SECTION B: #19 VBID - CASH OR MONETARY REBATES

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

Cash or Monetary Rebates amount per month: 41.50 Maximum Annual Cash or Monetary Rebates 498.00

available:

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C reductions

Flexibility/SSBCI benefit offer additional Part C

in cost?

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

Does your VBID/MA Uniformity

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

Uniformity Flexibility or SSBCI?

SSBCI

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

: Chronic alcohol and other drug dependence: To which chronic condition does this benefit

Autoimmune disorders: Cancer: Cardiovascular apply? (Select all that apply): disorders: Chronic heart failure: Dementia: Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS:

Chronic lung disorders: Chro: : : : : : Chronic lung

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

disorders

Other 1 Description: Crohn's disease or Ulcerative colitis

Other 2 Description: Anemia

Chronic obstructive pulmonary disease (COPD) Other 3 Description:

Other 4 Description: Severe mental retardation Other 5 Description: Moderate to Severe Autism

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

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**

No

Are you offering retroactive reimbursement?

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 - Home Assistance Services Maximum benefit coverage periodicity applies for Pest Control and General Supports for

Living - every three months.

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

: Pest Control: Transportation for Non-Medical 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 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

No

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 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 Three (3) 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-Medical Needs as a supplemental benefit under

Yes

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?

Indicate number of trips for Plan-approved

Location:

0



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

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

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 #1

Does the plan provide General Supports for Yes

Living as a supplemental benefit under Part C?

Select type of benefit for General Supports for Mandatory

Living:

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Notes:

Home Assistance - Twelve (12) visits per year (three

per quarter) for Home Assistance (Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance) 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-

Yes

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:

: In-Network Medicare-covered benefits

Does the In-Network Maximum Enrollee Out-of-

Pocket Cost apply to all In-Network Medicare-

covered plan services?

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Yes

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1 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 : Standard Retail: Out-of-Network: Standard Mail-

network (select all that apply): Order: Long-Term Care

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

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:

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

Standard Retail Cost Sharing - 3 month Supply

: Sponsor attests that it will comply with 42 CFR

Enter number of days for Standard Retail Cost

Sharing 1-month supply:

30





Enter number of days for Standard Retail Cost Sharing 2-month supply:	60
Enter number of days for Standard Retail Cost Sharing 3-month supply:	90
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:	30
Select all Standard Mail-Order Cost Sharing Location/supply amount(s) that apply:	: Standard Mail-Order - 3-month supply
Enter number of days for Standard Mail-Order Cost Sharing 3-month supply:	90
Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:	: Long-Term Care Pharmacy - 1-month supply
Enter number of days for Long-Term Care Pharmacy 1-month supply:	31
Are all of the drugs on your formulary available with an extended day supply?	No
Are any of the drugs available at an extended day supply limited to a 1-month supply for the first fill?	Yes
SECTION RX	K: VBID - GENERAL

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

No





MCS ADVANTAGE, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5577-036



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 036, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

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

Plan Ready for Upload Timestamp: 06/06/2021 05:14:29 PM SA Western Standard Time MA BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time PD BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time Last Upload File Creation Timestamp: 06/07/2021 05:13:57 PM SA Western Standard Time

Upload Status: 06/07/2021 #02307

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

> Completed Completed Completed

SECTION A: SECTION A-1

Completed

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Section B19 Status

Section C Status

Section D Status

Section Mrx Status

Organization Web Site: www.mcsclassicare.com

Plan Name: MCS Classicare Platino Recarga (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):	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
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:

2022

Plan Geographic Name:

Puerto Rico

Is this an Employer-Only plan?

No

SECTION A: SECTION A-2

Indicate CY2022 total projected member months

112750

for this plan:

Does this Plan have a CMS-approved

No

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

No

sharing plan (this does not apply to Part D

Services)?

Yes

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

Participating Pharmacy Website Address:

www.mcsclassicare.com

Formulary Website Address:

www.mcsclassicare.com www.mcsclassicare.com

Physician Website Address:

(866)627-8183

Customer Service Contact Phone Number for

Current Medicare Beneficiaries:

Customer Service Contact Local Phone Number

(787)620-2530

for Current Medicare Beneficiaries:

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

(866)627-8183

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone Number

(787)620-2530

for Current Part D Medicare Beneficiaries:

(866)627-8181

Customer Service Contact Phone Number for

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

(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:

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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 No Section B of the PBP? Is your organization filing a standard bid for No Section C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for No Section D of the PBP? Do any of your outpatient services have tiered No 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 No Out-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 period? Is authorization required? Yes Is a referral required for Inpatient Hospital-Acute Yes Services?

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

Does the plan provide Inpatient Hospital

No

Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Medicare-covered benefit cost

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

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?

Č

Original Medicare

Is authorization required?
Is a referral required for Inpatient Psychiatric

Hospital Services?

No

Yes

Notes: Preauthorization required through MCS Solutions,

except for Emergency and Urgency Services.

SECTION B: #2 SNF - BASE 1
Facility 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

Indicate the Number of Hospital Days Required

Prior to SNF Admission (0-2):

Zero

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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?

No

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

Does the plan provide Cardiac and Pulmonary

No

Rehabilitation Services as a supplemental benefit

under Part C?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?



CAOSDE

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary

No

Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

No

SECTION B: #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

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Coverage

Select type of benefit for Worldwide Emergency

Coverage:

Mandatory

Select type of benefit for Worldwide Urgent

Carraga

Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage

amount for Worldwide Emergency/Urgent

No

Coverage?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

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

Notes: 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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No **SECTION B: #5 PARTIAL HOSPITALIZATION - BASE 2** Is there an enrollee Copayment? No Yes Is authorization required? 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 No 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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No No Is there an enrollee Copayment? 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 Contrato Número Indicate number of visits for Routine Care: 6 Select Routine Care periodicity: Every year Is there a service-specific Maximum Plan Benefit No Coverage amount? Is there a service-specific Maximum Enrollee No

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

Out-of-Pocket Cost?



	ONAL THERAPY SERVICES - 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
Is there an enrollee Copayment?	No
SECTION B: #7C OCCUPATION	ONAL THERAPY SERVICES - BASE 2
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	Yes
SECTION B: #7D PHYSICIA	AN SPECIALIST SERVICES - 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
Is there an enrollee Copayment?	No
SECTION B: #7D PHYSICIA	AN SPECIALIST SERVICES - BASE 2
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes
SECTION B: #7E MENTAL HEA	ALTH SPECIALTY SERVICES - BASE 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #7E MENTAL HEA	ALTH 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 HEA	ALTH SPECIALTY SERVICES - BASE 3
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
SECTION B: #7F PO	DIATRY SERVICES - BASE 1
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	Preauthorization required through MCS Solutions: DIATRY SERVICES - BASE 1 No Contrato Número
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No 22 - 0 0 4
SECTION B: #7F POI	DIATRY SERVICES - BASE 2
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No ////C
Is there an enrollee Copayment?	No
SECTION B: #7F PO	DIATRY SERVICES - BASE 3
T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No.
Is authorization required?	No

SECTION B: #7G OTHER HE	ALTH CARE PROFESSIONAL - BASE 1
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
s there an enrollee Coinsurance?	No
s there an enrollee Deductible?	No
s there an enrollee Copayment?	No
SECTION B: #7G OTHER HE	ALTH CARE PROFESSIONAL - BASE 2
s authorization required?	No
s a referral required for Other Health Care Professional Services?	Yes
SECTION B: #7H PSY	CHIATRIC SERVICES - BASE 1
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
SECTION B: #7H PSY	CHIATRIC SERVICES - BASE 2
s there an enrollee Coinsurance?	No
s there an enrollee Deductible?	No
s there an enrollee Copayment?	No
	CHIATRIC SERVICES - BASE 3
s authorization required?	Yes
s a referral required for Psychiatric Services?	No
Notes:	Preauthorization required through MCS Solutions.
SECTION B: #7I PT	T AND SP SERVICES - BASE 1
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
s there an enrollee Coinsurance?	No
s there an enrollee Deductible?	No
s there an enrollee Copayment?	No No
SECTION B: #7I PT	No No T AND SP SERVICES - BASE 2
s authorization required?	Yes Contrato Número 2 - 0 0 4
s a referral required for Physical Therapy and Speech-Language Pathology Services?	Yes
SECTION B: #7J ADDITION.	AL TELEHEALTH SERVICES - BASE 1 POSDES
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	: 7a: Primary Care Physician Services: 7d: Physician Specialist Services: 7e1: Individual Sessions for Mental Health Specialty Services: 7h1: Individual Sessions for Psychiatric Services: 14e2: Diabetes Self-Management Training

No

No

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment? No SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE 3 Is authorization required for Additional No Telehealth Services? Is a referral required for Additional Telehealth No Services? SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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 No **Program Services?** SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 2 Is there an enrollee Coinsurance? No SECTION B: #8A OUTPATIENT DIAG PROCS/TESTS/LAB SERVICES - BASE 3 No Is there an enrollee Deductible? No Is there an enrollee Copayment? 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 No Out-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 Contrato Número Is authorization required? Yes -004Is a referral required for Outpatient Yes Diagnostic/Therapeutic Radiological, and X-Ray Services? POSDES SECTION B: #9A OUTPATIENT HOSPITAL SERVICES - BASE 1

No

Out-of-Pocket Cost? Is there an enrollee Coinsurance?

Is there a service-specific Maximum Enrollee

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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #9B ASC SERVICES - BASE 2** Is there an enrollee Deductible? No No Is there an enrollee Copayment? 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 No Out-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 Yes as a supplemental benefit under Part C? Select enhanced benefit: : Three (3) Pint Deductible Waived Contrato Número Select type of benefit for Three (3) Pint Mandatory Deductible Waived: QUAOS DES Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? 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 No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Maximum Enrollee 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

Does the plan provide Transportation Services as Yes

a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Health- Mandatory

Is this banafit unlimited for number of trine for

Is this benefit unlimited for number of trips for No

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved 52

Health-related Location:

Select Plan Approved Health-related Location Every year

Trips periodicity:

related Location:

Select Type of Transportation for Plan Approved One-way

Health-related Location:

Select Mode of Transportation for Plan : Medical Transport

Approved Health-related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan Benefit No

Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Yes

Select enhanced benefit: : Number of Treatments

Select type of benefit for Number of Treatments: Mandatory

Is this benefit unlimited for Number of

No

Treatments?

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

No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? Nο Is authorization required? No Is a referral required for Acupuncture? No

SECTION B: #13B OTC ITEMS - BASE 1 No

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

Items as a supplemental benefit under Part C?

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: #13D OTHER 1 - BASE 1

VBID - Air Conditioner or Refrigerator Enter name of Service (Optional):

Select type of benefit for Other 1: Mandatory

Is there a service-specific Maximum Plan Benefit Yes

Coverage amount?

500.00 Indicate Maximum Plan Benefit Coverage

amount:

Select Maximum Plan Benefit Coverage

periodicity:

Is there a service-specific Maximum Enrollee

No

Every year

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Out-of-Pocket Cost?

SECTION B: #13D OTHER 1 - BASE 2

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

SECTION B: #13D OTHER 1 - BASE 3

"Non-primarily health-related supplemental benefit" Notes: equivalent to \$500 for air conditioner or refrigerator, which must be obtained from plan-approved vendor. A designated service provider will perform an in-home safety assessment to ascertain suitability of equipment installation.

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.

No Is authorization required? 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*

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:

Indicate setting for Nutritional/Dietary Benefit:

Individual Sessions

Mandatory

6

Indicate type of Fitness Benefit offered (Select

all that apply):

: Physical Fitness

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

Select type of benefit for Fitness Benefit:

technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies

offered (Select all that apply):

: Web/Phone-based technologies: Nursing Hotline

POSDE

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

Select type of benefit for Alternative Therapies: Mandatory

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for Alternative

Therapies:

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

6

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No Indicate limit for number of sessions

Indicate the number of sessions periodicity:

Every year

SECTION B: #14C OTHER DEFINED SUPPLEMENTAL BENEFITS - BASE 4 No

Is there a service-specific Maximum Plan Benefit

Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Is authorization required?

No

Is a referral required for Other Defined

No

Supplemental Benefits?

Health Education Notes:

Health and preventive workshops, preventive care

reminders, and self-care guides. Healthy Welcome

Program - Coordination of initial healthy welcome visit. Guidance on preventive measures and actions to take in case of natural disasters and to reduce health

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0.0

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:*

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 15

Remote Access Technology (Web/Phone-based

technologies) Notes:*

Video doctor visits are intended to complement faceto-face visits with a board-certified physician to treat

the most common conditions, such as allergies, flu,

among others.

Remote Access Technologies (Nursing Hotline)

Nursing Hotline.

Notes:

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

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 is limited to six (6) visits per Therapeutic Massage Notes:

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 No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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 No **Education Services?** SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost for Other Medicare-covered Preventive Services? SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 2 Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No SECTION B: #14E OTHER MEDICARE-COVERED PREVENTIVE SERVICES - BASE 3 Is there an enrollee Copayment? No Is authorization required for Medicare-covered Nο 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? 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 Is there a Maximum Enrollee Out-of-Pocket No Cost? Is there an enrollee Coinsurance? No SECTION B: #15 MEDICARE PART B RX DRUGS - BA Is there an enrollee Copayment? No POSDE 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 No 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 No

a 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?

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

> Restorative Services: Endodontics: Periodontics: Extractions: Prosthodontics, Other Oral/Maxillofacial

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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: 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

1

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?

Yes

Mandatory

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

Is there a service-specific Maximum Plan Benefit

Coverage amount?

Select the Maximum Plan Benefit Coverage type:

Plan-specified amount per period

Indicate Maximum Plan Benefit Coverage

2000.00

amount:

Select the Maximum Plan Benefit Coverage

Every year

periodicity:

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

No

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

Is authorization required?

Yes

Is a referral required for Comprehensive Dental

No

Services?

SECTION B: #17A EYE EXAMS - BASE 1

Does the plan provide Eye Exams as a

Yes

supplemental benefit under Part C? Select enhanced benefit:

: Routine Eye Exams

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

1

Exams:

Select the Routine Eye Exams periodicity:

Every year

Is there a service-specific Maximum Plan Benefit

No

Coverage amount?

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

Is there an enrollee Deductible?

Nο

SECTION B: #17A EYE EXAMS - BASE 3

Is authorization required?

Select enhanced benefits:

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?

: 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

Mandatory

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

Is this benefit unlimited for Eyeglasses (lenses

Yes

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses:

Mandatory

Is this benefit unlimited for Eyeglass lenses?

Yes

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

Select the Maximum Plan Benefit Coverage type:

Coverage amount?

Plan-specified amount per period

Do you offer a Combined Max Plan Benefit

Yes

Yes

Coverage Amount for all Eyewear?

Indicate Combined Maximum Plan Benefit

600.00

Coverage amount:

Select the Combined Maximum Plan Benefit

Every year

Coverage periodicity:

SECTION B: #17B EYEWEAR - BASE 4

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

SECTION B: #17B EYEWEAR - BASE 5

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

SECTION B: #17B EYEWEAR - BASE 6

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

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:

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:

1

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

Out-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** 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

Mandatory

types):

Is this benefit unlimited for Hearing Aids (all

types)?

No, indicate number

2 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?

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

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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 Yes 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

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

Are you offering a VBID Hospice Benefit?

No Yes

Yes

Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives

programs should be entered in Section Rx)

In addition to wellness and health care planning,

what other interventions have you been approved

: Value-Based Design Flexibilities by Condition or Socioeconomic Status: Cash or Monetary Rebates

by CMMI to offer?

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

: Medicare Health Risk Assessment WHP Program Type (choose one or more): WHP Mode of Engagement (choose one or

: Telephonic: In-Person: Web-Based

more):

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?

No

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

activities?

No

Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.

: Provider/Patient portals: Data Warehouses

Expected Number of Beneficiaries to be Engaged

Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

5162

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

Cash or Monetary Rebates amount per month: 140.00 Maximum Annual Cash or Monetary Rebates

available:

1680.00

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C reductions

in cost?

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

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part C

benefits?

2 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

Uniformity Flexibility or SSBCI?

SSBCI



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

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence: Autoimmune disorders: Cancer: Cardiovascular disorders: Chronic heart failure: Dementia: Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS: Chronic lung disorders: Chro: : : : : : Chronic lung

disorders

Other 1 Description: Crohn's disease or Ulcerative colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive pulmonary disease (COPD)

Other 4 Description: Severe mental retardation
Other 5 Description: Moderate to Severe Autism

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

benefits offered in this package:

: 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

deductible?

No

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 - Home Assistance Services, Cell Phone Maximum benefit coverage periodicity applies for Pest Control and General

Supports for Living - every three months.

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: : Pest Control: Transportation for Non-Medical Needs:

General Supports for Living

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

No

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

No

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 Three (3) 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 Mandatory

Location:

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 : 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 No

Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

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

No

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 GENERAL SUPPORTS FOR LIVING - BASE 2: PACKAGE

No

No

#1

Is there an enrollee Coinsurance?

No
Is there an enrollee Deductible?

No

Is there an enrollee Copayment? No

Is authorization required?

Is a referral required for General Supports for

Living?

No
No
No
RAL SUPPORTS FOR LIVING - BASE 3: PACKAGE

NISTRACION

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

Notes: Home Assistance - Twelve (12) visits per year (three

per quarter) for Home Assistance (Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance) and categories listed under Pest Control. Cell Phone Benefit - Cellular data plan to improve or maintain the health or overall function of the enrollee.

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

Is this package applicable to VBID or MA

VBID

Uniformity Flexibility or SSBCI?

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

: Socioeconomic Status

Targeting Methodology - Please choose one or

both:

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

Expected Number of Enrollees to be Targeted: 5162
Expected Number of Enrollees to be engaged and 2581

receive Model benefits:

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

Is there a prerequisite for any additional benefits

for this package?

Which prerequisites are required for this

package?

Select all the Non-Medicare-covered additional

benefits offered in this package:

Yes

: Other, Describe

: 13d: Other 1

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

LEVEL DEDUCTIBLE): PACKAGE #2 Are any benefits exempt from the plan-level

deductible?

No

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

Are you offering retroactive reimbursement? No Is there a maximum benefit amount? Yes Specify the maximum benefit amount: 500.00

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

Notes: "Non-primarily health-related supplemental benefit"

> equivalent to \$500 for air conditioner or refrigerator. A designated service provider will perform an in-home safety assessment to ascertain suitability of equipment

> > Contrato Número

POSDE

installation.

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 Outof-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

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Yes

No Do you offer Reductions in Cost Sharing?

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits No

with uniform cost sharing?

SECTION RX: MEDICARE RX GENERAL 1

Does your plan offer a Medicare Prescription

drug (Part D) benefit?

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

Does plan utilize floor pricing? Does plan utilize ceiling pricing? Do you pay for over-the-counter medications (OTCs) under the utilization management program?

No 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:

30

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

60

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

: Out-of-Network Pharmacy - one month supply

: Long-Term Care Pharmacy - 1-month supply

Contrato Número

: Standard Mail-Order - 3-month supply

Enter number of days for Out-of-Network

Pharmacy 1-month supply:

30

90

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:

31

Are all of the drugs on your formulary available

with an extended day supply?

No

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

Yes

fill?

SECTION RX: VBID - GENERAL

Are you offering Part D Benefits and/or Part D

Rewards and Incentives under the VBID

Model?

PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

No

MCS ADVANTAGE, INC.

APPENDIX C-1 PLAN BENEFIT PACKAGE (PBP) H5577-037



DATA REPORT FOR Contract H5577, PLAN 037, SEGMENT 0

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

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

Plan Ready for Upload Timestamp: 06/06/2021 05:14:45 PM SA Western Standard Time MA BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time PD BPT Timestamp: 06/07/2021 04:59:41 PM SA Western Standard Time Last Upload File Creation Timestamp: 06/07/2021 05:13:57 PM SA Western Standard Time

Upload Status: 06/07/2021 #02307

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 A: SECTION A-1

Completed

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-SM

Organization Type: Local CCP

Section Mrx Status

Plan Type:	НМО
Enrollee Type:	Part A and Part B
Service Area(s):	40010 - Adjuntas, PR
	<u>-</u>
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):	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
• •	40300 - Guaynabo, PR
Service Area(s):	•
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
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:	037
Segment ID:	0
	0000

2022

Contract Period:



Plan Geographic Name: Puerto Rico

Is this an Employer-Only plan? No

SECTION A: SECTION A-2

23615

No

Yes

No

Yes

Indicate CY2022 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

Dual-Eligible 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?

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 (866)627-8183

Current Medicare Beneficiaries:

Customer Service Contact Local Phone (787)620-2530

Number for Current Medicare Beneficiaries:

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

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone (787)620-2528

Number for Prospective Medicare

Beneficiaries:

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

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone (787)620-2530

Number for 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 (787)620-2528

Number for Prospective Part D Medicare

Beneficiaries:

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

Current 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 (866)627-8182 Current 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 No Section B of the PBP? Is your organization filing a standard bid for No Section C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for No Section D of the PBP? Do any of your outpatient services have tiered No 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 No Out-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

period?

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

Acute Services?

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

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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

Does this plan's Medicare-covered benefit cost

sharing vary by hospital(s) in which an enrollee

obtains care?

Is there an enrollee Coinsurance? No

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

No

No

What is your Inpatient Hospital Psychiatric

benefit period?

Original Medicare

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

Hospital Services?

Preauthorization required through MCS Solutions,

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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?

Notes:

Do you allow less than 3 day inpatient hospital

stay 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?

Zero

Yes

No

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?

No

No

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

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-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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 No Pulmonary Rehabilitation Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? No

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

Is there an enrollee Copayment? No

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? Nο

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

No

Is there an enrollee Copayment? No

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

Select type of benefit for Worldwide Mandatory

Emergency Coverage:

Select type of benefit for Worldwide Urgent Mandatory

Coverage:

Is there a Maximum Plan Benefit Coverage No

amount for Worldwide Emergency/Urgent

Coverage?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

Is there an enrollee Deductible? No Contrato Número

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

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 No

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-of-Pocket Cost?

No

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 Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

a supplemental benefit under Part C?

Yes

No

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 there a service-specific Maximum Plan

Benefit Coverage amount?

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Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Copayment?

No
Is there an enrollee Deductible?

No

Is authorization required? No

Is a referral required for Chiropractic Services? Yes

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance? 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 No

Out-of-Pocket Cost?

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

SECTION B: #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 No

Out-of-Pocket Cost?

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

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

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

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

Specialty Services - Non-Physician?

Notes: Preauthorization required through MCS Solutions.

SECTION B: #7F PODIATRY SERVICES - BASE 1

Does the plan provide Podiatry Services as a

supplemental benefit under Part C?

No



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Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7F PODIATRY SERVICES - BASE 2

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

SECTION B: #7F PODIATRY SERVICES - BASE 3

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 3

Is authorization required? 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 No

Out-of-Pocket Cost?

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

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

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

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE

Do you offer an Additional Telehealth benefit Yes

for Part B services?

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

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

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

No

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

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

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

No

No

Is authorization required for Additional

Telehealth Services?

Is a referral required for Additional Telehealth No

Services?

SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 10 s

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 No

Program Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

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

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

Is authorization required? Yes

Is a referral required for Outpatient Diagnostic Yes

Procedures/Test/Lab Services?

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

No

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

Yes

Is authorization required?

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-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

No

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

Observation Services?

Is a referral required for Medicare-covered

Outpatient Hospital Services?

Is a referral required for Medicare-covered

Observation Services?

No

Yes

No

SECTION B: #9B ASC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee

Out-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 No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

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

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

Abuse?

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

Does the plan provide Outpatient Blood Yes

Services as a supplemental benefit under Part

C?





Select enhanced benefit: : Three (3) Pint Deductible Waived Select type of benefit for Three (3) Pint Mandatory Deductible Waived: Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? 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 No Services? SECTION B: #10A AMBULANCE SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No **SECTION B: #10A AMBULANCE SERVICES - BASE 2** Is there an enrollee Deductible? No Is there an enrollee Copayment? No **SECTION B: #10A AMBULANCE SERVICES - BASE 3** Is authorization required for non-emergency Yes Medicare services? SECTION B: #10B TRANSPORTATION SERVICES - BASE 1 Does the plan provide Transportation Services Yes as a supplemental benefit under Part C? Select enhanced benefit: Plan Approved Health-related Location Select type of benefit for Plan Approved Mandatory Health-related Location: Is this benefit unlimited for number of trips for No Plan Approved Health-related Location? Indicate number of trips for Plan Approved 24 Contrato Número Health-related Location: Select Plan Approved Health-related Location Every year Trips periodicity: Select Type of Transportation for Plan One-way Approved Health-related Location: Select Mode of Transportation for Plan : Medical Transport Approved Health-related Location: **SECTION B: #10B TRANSPORTATION SERVICES - BASE 2**

No

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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



SECTION B: #10B TRANSPORTATION SERVICES - BASE 3

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

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 No

Out-of-Pocket Cost?

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

SECTION B: #11A DME - BASE 2

Yes

Are there preferred vendors/manufacturers for

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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.

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

those from specified manufacturers?

**

Is authorization required? 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 No

Out-of-Pocket Cost?

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

SECTION B: #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 Mandatory

Treatments:

Is this benefit unlimited for Number of No

Treatments?

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 No

Out-of-Pocket Cost?

SECTION B: #13A ACUPUNCTURE - BASE 2

No

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 No

(OTC) Items as a supplemental benefit under

Part C?

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal No

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 : I attest that there is no coinsurance, copayment, or

Services Attestation deductible for all Original Medicare preventive services

that are offered at zero dollar cost sharing.

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Is authorization required? No Is a referral required? No

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

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

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

Benefit: 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:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

Is this benefit unlimited for Nutritional/Dietary

Benefit?

letary No, indicate number

6

Indicate number of visits for

Nutritional/Dietary Benefit:

Indicate setting for Nutritional/Dietary Benefit: Individual Sessions

Select type of benefit for Fitness Benefit: M

Indicate type of Fitness Benefit offered (Select

Select the type of Remote Access Technologies

all that apply):

Mandatory

: Physical Fitness

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

technologies and Nursing Hotline):

Mandatory

: 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 Mandatory

Therapies:

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for 6

Alternative Therapies:

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

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No Indicate limit for number of sessions 6

Indicate the number of sessions periodicity: Every year

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

Is there a service-specific Maximum Plan

No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

No

Is there an enrollee Coinsurance?

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

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

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

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

Supplemental Benefits?

Health Education Notes: Health and preventive workshops, preventive care

reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. 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:* 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 15

Remote Access Technology (Web/Phone-based

technologies) Notes:*

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

others.

Remote Access Technologies (Nursing

Hotline) Notes:

Nursing Hotline.

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

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? No



Is a referral required for Kidney Disease

Education Services?

No

No

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? No
Is there an enrollee Deductible? No

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

No

No

No

No

No

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

Barium Enemas?

Is authorization required for Medicare-covered

Digital Rectal Exams?

Is authorization required for Medicare-covered

EKG following Welcome Visit?

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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?

Is there an enrollee Coinsurance?

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

Is there an enrollee Copayment?

Is there an enrollee Deductible?

No
Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

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

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion No

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 No as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental Yes

Items as a supplemental benefit under Part C?



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

Services: Endodontics: Periodontics: Extractions:

Prosthodontics, Other Oral/Maxillofacial Surgery, Other

Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine

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 1

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

1

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?

Yes

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 3

Plan-specified amount per period

Mandatory

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:

Every year

2000.00

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 4

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



SECTION B: #16B COMPREHENSIVE DENTAL - BASE 5

Is there an enrollee Copayment?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 6

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

Services?

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 No. indicate number

Exams?

Indicate number of exams for Routine Eye 1

Exams:

Select the Routine Eye Exams periodicity: Every year

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: #17A EYE EXAMS - BASE 2

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

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 Mandatory

and 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



Is there a service-specific Maximum Plan

Benefit Coverage amount?

Yes

Select the Maximum Plan Benefit Coverage

type:

Plan-specified amount per period

Do you offer a Combined Max Plan Benefit

Coverage Amount for all Eyewear?

Yes

Indicate Combined Maximum Plan Benefit

Coverage amount:

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Every year

500.00

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? 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

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

Aid

Select type of benefit for Routine Hearing

Exams:

Mandatory

Is this benefit unlimited for Routine Hearing

Exams?

No, indicate number

Indicate number for Routine Hearing Exams: 1

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

Hearing Aid:

Every year

Mandatory

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

ricaring Aid.

Every year

periodicity:

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

1



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

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

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

Mandatory

types):

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

ADMINISTR40

Contrato Núme

Indicate Maximum Plan Benefit Coverage

amount:

2000.00

Indicate Maximum Plan Benefit Coverage

periodicity:

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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?

Do you offer Special Supplemental Benefits

for the Chronically Ill?

Yes

No

Yes

No

Select what type of benefit your SSBCI

includes:

Additional Benefits

Are you offering a VBID Hospice Benefit?

Are you offering Part C benefits under the

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

In addition to wellness and health care planning, what other interventions have you

been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition or Socioeconomic Status: Cash or Monetary Rebates

Value-Based Insurance Design Attestation : Lattest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

WHP Program Type (choose one or more): : Medicare Health Risk Assessment WHP Mode of Engagement (choose one or : Telephonic: In-Person: Web-Based

more):

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

No

No

743

Does your organization offer provider incentives for offering or engaging

beneficiaries in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be

Engaged Annually:

: Provider/Patient portals: Data Warehouses

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

Cash or Monetary Rebates amount per month: 135.00 Maximum Annual Cash or Monetary Rebates

available:

1620.00

SECTION B: #19 VBID - CASH OR MONETARY REBATES

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

Does your VBID/MA Uniformity No

Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

1

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

Benefits contain? (1-15)



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-0.0

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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #1

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence: Autoimmune disorders: Cancer: Cardiovascular

disorders: Chronic heart failure: Dementia: Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS: Chronic lung

disorders: Chro: ::::: Chronic lung disorders

Other 1 Description: Crohn's disease or Ulcerative colitis

Other 2 Description: Anemia

Other 3 Description: Chronic obstructive pulmonary disease (COPD

Other 4 Description: Severe mental retardation
Other 5 Description: Moderate to Severe Autism

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

benefits offered in this package:

: 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

deductible?

No

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:

includes:

The following SSBCI benefits will be offered: - Pest Control - Transportation for Non-Medical Needs -General Supports for Living - Home Assistance Services Maximum benefit coverage periodicity applies for Pest Control and General Supports for Living - every three

months.

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 III

: Pest Control: Transportation for Non-Medical Needs:

General Supports for Living

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

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

Yes

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22 - 0 0 4

Select type of benefit for Pest Control:

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

No

Mandatory

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?

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 Three (3) 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?

Select enhanced benefit: Plan-approved Location

Select type of benefit for Plan-approved Mandatory

Location:

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 Every year

periodicity:

Select Type of Transportation for Non-Medical One-way

Needs for Plan-approved Location:

Select Mode of Transportation for Non- Medical Transport: Other, Describe

Medical Need for Plan-approved Location:

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

No

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?



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 No

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 #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

No

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

Notes: Home Assistance - Twelve (12) visits per year (three per

> quarter) for Home Assistance (Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance) 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

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?

Voluntary

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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

Does the In-Network Maximum Enrollee Out-

of-Pocket Cost apply to all In-Network

Medicare-covered plan services?

Yes

SECTION D: REDUCTIONS IN COST SHARING - GENERAL

Do you offer Reductions in Cost Sharing?

No

SECTION D: COMBINED BENEFITS - GENERAL

Do you offer Combined Supplemental Benefits

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

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

30

30

Standard Retail Cost Sharing - 3 month Supply SHINISTRACION

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

Sharing 3-month supply:

90

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: : Out-of-Network Pharmacy - one month supp

: Standard Mail-Order - 3-month supply

90

: Long-Term Care Pharmacy - 1-month supply



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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?

No

31

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

Yes

first fill?

SECTION RX: VBID - GENERAL

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



MCS ADVANTAGE, INC.

APPENDIX C-1
PLAN BENEFIT PACKAGE (PBP)
H5577-041



PLAN BENEFIT PACKAGE (PBP) DATA ENTRY SYSTEM DATA REPORT

DATA REPORT FOR Contract H5577, PLAN 041, SEGMENT 0.

Module: PBP Requested By: d3ua

PLAN SYSTEM INFORMATION

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

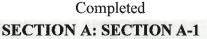
Plan Ready for Upload Timestamp: 06/06/2021 05:15:39 PM SA Western Standard Time MA BPT Timestamp: 06/07/2021 04:59:42 PM SA Western Standard Time PD BPT Timestamp: 06/07/2021 04:59:42 PM SA Western Standard Time Last Upload File Creation Timestamp: 06/07/2021 05:13:57 PM SA Western Standard Time

Upload Status: 06/07/2021 #02307

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



Completed

Organization Legal Name: MCS ADVANTAGE, INC.

Organization Marketing Name: MCS Classicare

Section D Status

Section Mrx Status

Organization Web Site: www.mcsclassicare.com

Plan Name: MCS Classicare Platino Solido (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):	40060 - Anasco, PR
Service Area(s):	40070 - Arecibo, PR
Service Area(s):	40090 - Barceloneta, PR
Service Area(s):	40120 - Cabo Rojo, PR
Service Area(s):	40140 - Camuy, PR
Service Area(s):	40190 - Ciales, PR
Service Area(s):	40230 - Corozal, PR
Service Area(s):	40265 - Florida, PR
Service Area(s):	40270 - Guanica, PR
Service Area(s):	40290 - Guayanilla, PR
Service Area(s):	40320 - Hatillo, PR
Service Area(s):	40330 - Hormigueros, PR
Service Area(s):	40350 - Isabela, PR
Service Area(s):	40360 - Jayuya, PR
Service Area(s):	40370 - Juana Diaz, PR
Service Area(s):	40390 - Lajas, PR
Service Area(s):	40400 - Lares, PR
Service Area(s):	40410 - Las Marias, PR
Service Area(s):	40450 - Manati, PR
	40460 - Maricao, PR
Service Area(s):	40480 - Mayaguez, PR
Service Area(s):	40490 - Moca, PR
Service Area(s):	
Service Area(s):	40500 - Morovis, PR
Service Area(s):	40530 - Orocovis, 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):	40610 - Sabana Grande, PR
Service Area(s):	40630 - San German, PR
Service Area(s):	40660 - San Sebastian, PR
Service Area(s):	40710 - Utuado, PR
Service Area(s):	40720 - Vega Alta, PR
Service Area(s):	40730 - Vega Baja, PR
Service Area(s):	40750 - Villalba, PR
Service Area(s):	40770 - Yauco, PR



Contract Number: H5577
Plan ID: 041

Segment ID: 0

Contract Period: 2022

Plan Geographic Name: Puerto Rico West 39

Is this an Employer-Only plan?

SECTION A: SECTION A-2

Indicate CY2022 total projected member 99150

months for this plan:

Does this Plan have a CMS-approved No

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 Yes

all Medicare premiums and cost sharing for

enrollees in your D-SNP?

SECTION A: SECTION A-3

No

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 (787)620-2530

Number for Current Medicare Beneficiaries:

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

Prospective Medicare Beneficiaries:

Customer Service Contact Local Phone (787)620-2528

Number for Prospective Medicare

Beneficiaries:

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

Current Part D Medicare Beneficiaries:

Customer Service Contact Local Phone (787)620-2530

Number for 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 (787)620-2528

Number for Prospective Part D Medicare

Beneficiaries:



Customer Service Contact TTY/TDD for (866)627-8182 Current 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 (866)627-8182 Current 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 No Section B of the PBP? Is your organization filing a standard bid for No Section C of the PBP? **SECTION A: SECTION A-6** Is your organization filing a standard bid for No Section D of the PBP? Do any of your outpatient services have tiered No 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 No

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

obtains care?

Is there an enrollee Coinsurance?

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

Is authorization required? Yes





Is a referral required for Inpatient Hospital-

Acute Services?

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

Does the plan provide Inpatient Hospital No Psychiatric Services as a supplemental benefit

under Part C?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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?

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

Does the plan provide Skilled Nursing Facility

Services as a supplemental benefit under Part

C?

Do you allow less than 3 day inpatient hospital Yes

stay prior to SNF admission?

Indicate the Number of Hospital Days Zero

Required Prior to SNF Admission (0-2):

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

No

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 Does the plan provide Cardiac and Pulmonary No Rehabilitation Services as a supplemental benefit under Part C? SECTION B: #3 CARDIAC AND PULMONARY REHABILITATION SERVICES - BASE 2 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No 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 No Pulmonary Rehabilitation Services? SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #4A EMERGENCY/POST-STABILIZATION SERVICES - BASE 2 Is there an enrollee Copayment? No SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No SECTION B: #4B URGENTLY NEEDED SERVICES - BASE 2 Is there an enrollee Copayment? No SECTION B: #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 Mandatory **Emergency Coverage:** Select type of benefit for Worldwide Urgent Mandatory Contrato Número Coverage: 0 Is there a Maximum Plan Benefit Coverage No amount for Worldwide Emergency/Urgent GUROS DE Coverage? Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

No

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?

Is authorization required?

Yes

Is a referral required for Partial

No

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-of-Pocket Cost?

No

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 Yes

Services?

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

No
Is there an enrollee Copayment?

No

SECTION B: #7B CHIROPRACTIC SERVICES - BASE 1

Does the plan provide Chiropractic Services as

a supplemental benefit under Part C?

Yes

No

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 there a service-specific Maximum Plan

Benefit Coverage amount?

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Is there a service-specific Maximum Enrollee No

Out-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 No

Out-of-Pocket Cost?

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

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 No

Out-of-Pocket Cost?

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

SECTION B: #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 No

Out-of-Pocket Cost?

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

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

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

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

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

supplemental benefit under Part C?

No



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Is there a service-specific Maximum Enrollee No

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

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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

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

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

Professional Services?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

SECTION B: #7H PSYCHIATRIC SERVICES - BASE 2

Is there an enrollee Coinsurance? 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.

No

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

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

Speech-Language Pathology Services?

SECTION B: #7J ADDITIONAL TELEHEALTH SERVICES - BASE

Do you offer an Additional Telehealth benefit Yes

for Part B services?

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

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

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

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

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

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

Is authorization required for Additional

Telehealth Services?

No

No

Services?

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

Is there a service-specific Maximum Enrollee

Is a referral required for Additional Telehealth

Out-of-Pocket Cost?

No

No

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

Is there an enrollee Copayment?

No SECTION B: #7K OPIOID TREATMENT PROGRAM SERVICES - BASE 2

Is authorization required? No

Is a referral required for Opioid Treatment

No

Program Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost?

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

Is there an enrollee Coinsurance?

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

Is authorization required?

Is a referral required for Outpatient Diagnostic

Procedures/Test/Lab Services?

Yes Contrato Número

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

Yes

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

No

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 No Out-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 No Out-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 No Out-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 Yes

Services as a supplemental benefit under Part

C?



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

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

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

Is there an enrollee Deductible?

Is there an enrollee Copayment?

No
Is authorization required?

No
Is a referral required for Outpatient Blood

No

Services?

SECTION B: #10A AMBULANCE SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

SECTION B: #10A AMBULANCE SERVICES - BASE 2

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

SECTION B: #10A AMBULANCE SERVICES - BASE 3

Is authorization required for non-emergency Yes

Medicare services?

SECTION B: #10B TRANSPORTATION SERVICES - BASE 1

No

Does the plan provide Transportation Services Yes

as a supplemental benefit under Part C?

Select enhanced benefit: Plan Approved Health-related Location

Select type of benefit for Plan Approved Mandatory

Health-related Location:

Is this benefit unlimited for number of trips for

Plan Approved Health-related Location?

Indicate number of trips for Plan Approved 30

Health-related Location:

Trips periodicity:

Select Type of Transportation for Plan One-way

Approved Health-related Location:

Select Mode of Transportation for Plan : Medical Transport

Approved Health-related Location:

SECTION B: #10B TRANSPORTATION SERVICES - BASE 2

Is there a service-specific Maximum Plan No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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



SECTION B: #10B TRANSPORTATION SERVICES - BASE 3 Is there an enrollee Copayment? No Is authorization required? No Is a referral required for Transportation No Services? Notes: Transportation to Plan-Approved Location provided by contracted transportation provider. **SECTION B: #11A DME - BASE 1** Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? No Is there an enrollee Deductible? No Is there an enrollee Copayment? No SECTION B: #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 services) is Notes: managed through Referral/Authorization Form. SECTION B: #11B PROSTHETICS/MEDICAL SUPPLIES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Is there an enrollee Coinsurance? Nο 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? Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. SMINISTRACION PORTON SECTION B: #11C DIABETIC SUPPLIES AND SERVICES - BASE 1 Is there a service-specific Maximum Enrollee No Out-of-Pocket Cost? Contrato Número Is there an enrollee Coinsurance? No = 0 0 4

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

Pre-authorization by PCP (for corresponding services) is Notes:

managed through Referral/Authorization Form.

SECTION B: #12 DIALYSIS SERVICES - BASE 1

Is there a service-specific Maximum Enrollee No

Out-of-Pocket Cost?

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

SECTION B: #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

Mandatory

Treatments:

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

No

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

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 Is a referral required for Acupuncture? Nο

SECTION B: #13B OTC ITEMS - BASE 1

Does the plan provide Over-The-Counter

No

(OTC) Items as a supplemental benefit under

Part C?

SECTION B: #13C MEAL BENEFIT - BASE 1

Does the plan provide a limited duration Meal

No

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

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that are offered at zero dollar cost sharing.

Is authorization required? No Is a referral required? No



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

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

Does the plan provide Other Defined

Yes

Supplemental Benefits as a benefit under Part

C?

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

Benefit: 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:

Select type of benefit for Nutritional/Dietary

Benefit:

Mandatory Mandatory

6

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: Individual Sessions

Select type of benefit for Fitness Benefit: Mandatory

Indicate type of Fitness Benefit offered (Select

all that apply):

: 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 : 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 Mandatory

Therapies:

Is this benefit unlimited for Alternative No, indicate number

Therapies?

Indicate number of visits offered for 6

Alternative Therapies:

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

Select type of benefit for Therapeutic Massage: Mandatory

Is this benefit unlimited? No Indicate limit for number of sessions 6

Indicate the number of sessions periodicity: Every year

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

Is there a service-specific Maximum Plan No

Benefit Coverage amount for Other Defined

Supplemental Benefits?

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

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost for Other Defined

Supplemental Benefits?

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

No

Is there an enrollee Coinsurance? No

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

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

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

Is authorization required? No No

Is a referral required for Other Defined

Supplemental Benefits? Health Education Notes:

Health and preventive workshops, preventive care

reminders, and self-care guides. Healthy Welcome Program - Coordination of initial healthy welcome visit. 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:* 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 15

Remote Access Technology (Web/Phone-based

technologies) Notes:*

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

others.

Remote Access Technologies (Nursing

Hotline) Notes:

Nursing Hotline.

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

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 is limited to six (6) visits per year Therapeutic Massage Notes:

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 SEAS

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

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Is a referral required for Kidney Disease

No

Education Services?

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

Is there a service-specific Maximum Enrollee

No

Out-of-Pocket Cost for Other Medicare-

covered Preventive Services?

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

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

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

Is there an enrollee Copayment?

No

Is authorization required for Medicare-covered

No

Glaucoma Screening?

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?

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

Is a referral required for any Services?

No

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

Is there a Maximum Enrollee Out-of-Pocket

No

Cost?

Is there an enrollee Coinsurance?

No

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

Is there an enrollee Copayment?

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

: Part B to Part B?: Part D to Part B?

apply):

SECTION B: #15 HOME INFUSION BUNDLED SERVICES

Does the plan provide Part D home infusion

No

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

No

as a supplemental benefit under Part C?

SECTION B: #16B COMPREHENSIVE DENTAL - BASE 1

Does the plan provide Comprehensive Dental

Yes

Items as a supplemental benefit under Part C?



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

Services: Endodontics: Periodontics: Extractions:

Prosthodontics, Other Oral/Maxillofacial Surgery, Other

Services

Select type of benefit for Non-routine Services: Mandatory

Is this benefit unlimited for Non-routine

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

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

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:

3000.00

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? 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

No

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

Services?

SECTION B: #17A EYE EXAMS - BASE 1

No, indicate number

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?

1

Indicate number of exams for Routine Eye

Exams:

Select the Routine Eye Exams periodicity: Every year

Is there a service-specific Maximum Plan

No

No

Benefit Coverage amount?

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

SECTION B: #17A EYE EXAMS - BASE 2

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

SECTION B: #17A EYE EXAMS - BASE 3

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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:

Is this benefit unlimited for Contact lenses?

Mandatory Yes

Select type of benefit for Eyeglasses (lenses

Mandatory

and frames):

Is this benefit unlimited for Eyeglasses (lenses

Yes

and frames)?

SECTION B: #17B EYEWEAR - BASE 2

Select type of benefit for Eyeglass lenses: Mandatory

Is this benefit unlimited for Eyeglass lenses? Yes

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?

Plan-specified amount per period

type:

Do you offer a Combined Max Plan Benefit

Select the Maximum Plan Benefit Coverage

Coverage Amount for all Eyewear?

Yes

Yes

Indicate Combined Maximum Plan Benefit

Coverage amount:

750.00

Select the Combined Maximum Plan Benefit

Coverage periodicity:

Every year

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? 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

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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

Exams?

No, indicate number

Indicate number for Routine Hearing Exams: 1

Select Routine Hearing Exams periodicity:

Select type of benefit for Fitting/Evaluation for

Hearing Aid:

Every year Mandatory

Mandatory

Is this benefit unlimited for Fitting/Evaluation

for Hearing Aid?

No, indicate number

Indicate number for Fitting/Evaluation for

Hearing Aid:

1

Select Fitting/Evaluation for Hearing Aid

periodicity:

Every year

SECTION B: #18A HEARING EXAMS - BASE 2

Is there a service-specific Maximum Plan

Benefit Coverage amount?

No

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 HEA

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

Mandatory

No, indicate number

Both ears combined

Plan-specified amount per period

0.04

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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):

Is this benefit unlimited for Hearing Aids (all

types)?

Indicate quantity for Hearing Aids (all types): 2

Select Hearing Aids (all types) periodicity: Every year

SECTION B: #18B HEARING AIDS - BASE 2

Yes

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:

2500.00

Every year

SECTION B: #18B HEARING AIDS - BASE 3

Is there a service-specific Maximum Enrollee

Out-of-Pocket Cost?

Is there an enrollee Coinsurance?

No

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 No 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:

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

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

Section Rx)

In addition to wellness and health care planning, what other interventions have you

been approved by CMMI to offer?

: Value-Based Design Flexibilities by Condition or Socioeconomic Status: Cash or Monetary Rebates

: Provider/Patient portals: Data Warehouses

Value-Based Insurance Design Attestation : I attest that

SECTION B: #19 VBID WELLNESS AND HEALTH CARE PLANNING

No

No

Yes

: Additional Benefits

WHP Program Type (choose one or more): Medicare Health Risk Assessment WHP Mode of Engagement (choose one or : Telephonic: In-Person: Web-Based

more):

Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of

WHP Services?

Does your organization offer provider incentives for offering or engaging

beneficiaries in WHP activities?

Program Connectedness: Please check the way

that advance care plans and/or advance

directives are connected from your program to

access points of care.

Expected Number of Beneficiaries to be 5162

Engaged Annually:

SECTION B: #19 VBID - CASH OR MONETARY REBATES

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

Cash or Monetary Rebates amount per month: 210.00 Maximum Annual Cash or Monetary Rebates 2520.00

available:

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

Does your VBID/MA Uniformity No Flexibility/SSBCI benefit offer Part C

reductions in cost?

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

1

Does your VBID/MA Uniformity Yes

Flexibility/SSBCI benefit offer additional Part

C benefits?

How many packages do your Additional

Benefits contain? (1-15)



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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 - CHRONIC CONDITIONS: SSBCI: PACKAGE #1

To which chronic condition does this benefit

apply? (Select all that apply):

: Chronic alcohol and other drug dependence:

Autoimmune disorders: Cancer: Cardiovascular disorders: Chronic heart failure: Dementia: Diabetes: End-stage liver disease: End-stage renal disease (ESRD): Severe hematologic disorders: HIV/AIDS: Chronic lung disorders: Chro::::::: Chronic lung

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disorders

Other 1 Description:

Crohn's disease or Ulcerative colitis

Other 2 Description:

Anemia

Other 3 Description:

Chronic obstructive pulmonary disease (OO)

Severe mental retardation

Other 4 Description: Other 5 Description:

Moderate to Severe Autism

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

Is there a prerequisite for any additional

benefits for this package?

No

Select all the Non-Medicare-covered additional

benefits offered in this package:

: 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

deductible?

No

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 - Home Assistance Services Maximum benefit coverage periodicity applies for Pest

Control and General Supports for Living - every three

months.

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 : Pest Control: Transportation for Non-Medical 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 supplemental benefit under Part C?

Yes

Select type of benefit for Pest Control:

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 PEST CONTROL - BASE 2: PACKAGE #1

Mandatory

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

Notes: Services listed in this category will be combined with

> those filed under SSBCI Category "General Supports for Living". Member will choose up to Three (3) 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

Mandatory

Yes

0

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:

Is this benefit unlimited for number of trips for No

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

Needs for Plan-approved Location:

Select Mode of Transportation for Non-: Medical Transport: Other, Describe

Medical Need for Plan-approved Location:

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

One-way

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

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 No

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?

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 - BA #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 General Supports for No

Living?

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

Notes: Home Assistance - Twelve (12) visits per year (three per

quarter) for Home Assistance (Plumbing, Electricity, Locksmith, Pet Grooming, Technology Assistance) 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:

: 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

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

No

No

Does plan utilize floor pricing?

Does plan utilize ceiling pricing? 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: Location/supply amount(s) that apply: Standard Retail Cost Sharing - 2 month Supply:

Standard Retail Cost Sharing - 3 month Supply

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Enter number of days for Standard Retail Cost

Sharing 1-month supply:

Enter number of days for Standard Retail Cost

Sharing 2-month supply:

60

30

Enter number of days for Standard Retail Cost

Sharing 3-month supply:

90

Select all Out-of-Network Pharmacy

Location/supply amount(s) that apply:

Enter number of days for Out of Network

Pharmacy 1-month supply:

: Out-of-Network Pharmacy - one month supplys of

Enter number of days for Out-of-Network 30

Select all Standard Mail-Order Cost Sharing

Location/supply amount(s) that apply:

: Standard Mail-Order - 3-month supply

Enter number of days for Standard Mail-Order

Cost Sharing 3-month supply:

90

Select the Long-Term Care Pharmacy one month Location/supply amount(s) that apply:

: Long-Term Care Pharmacy - 1-month supply

Enter number of days for Long-Term Care

Pharmacy 1-month supply:

No

31

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

Are any of the drugs available at an extended

Yes

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

SECTION RX: VBID - GENERAL

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

