

# **APPENDIX C (1)**

Medicare Advantage Plan

Benefit Package PBP

# Appendix C-1

## Plan Benefit Package (PBP)

### H5577 – 017

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 017

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Progreso (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 0  
Segment Geographic Name: null  
Status: Version 3 - Renewal - Successfully exported to desk review (06/06/23)  
Plan Type: HMO  
Enrollee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Special Needs Plan Type: Dual-Eligible  
Special Needs Plan Type: Medicare non-zero dollar cost sharing plan  
Dual-Eligible SNP: Yes  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? No  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

### Plan Level Data

Question

Response

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**Tiered Cost sharing for Part B Services**

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



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

|  |                 |
|--|-----------------|
| <b>1a Inpatient Hospital-Acute</b>       |                 |
| <b>Service Category Description</b>      |                 |
| <b>Benefit Description</b>               |                 |
| <b>Question</b>                          | <b>Response</b> |
| <b>1b Inpatient Hospital-Psychiatric</b> |                 |
| <b>Service Category Description</b>      |                 |
| <b>Benefit Description</b>               |                 |

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|   |                 |
|---|-----------------|
| <b>Question</b>   | <b>Response</b> |
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No              |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No              |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

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

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

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

**4c Worldwide Emergency/Urgent Coverage**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**

**Service Category Description**

**Benefit Description**

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

**6 Home Health Services**

**Service Category Description**

**Benefit Description**

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

**7a Primary Care Physician Services**

**Service Category Description**

**Benefit Description**

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

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**7b Chiropractic Services**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**

**Service Category Description**

**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

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

**7e Mental Health Specialty Services**

| Benefit Description  |  |
|--|--|
| Question   | Response   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?             | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Is authorization required?   | Yes  |
| Is a referral required for Mental Health Specialty Services - Non-Physician? | No   |
| Notes:   | Preauthorization required through MCS Solutions. |
| Notes:   | Preauthorization required through MCS Solutions. |

**7f Podiatry Services**

| Benefit Description |          |
|---------------------|----------|
| Question            | Response |
|                     |          |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

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**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Psychiatric Services?                            | No       |

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Coinsurance?                             | No       |
| Is there an enrollee Deductible?                              | No       |
| Is there an enrollee Copayment?                               | No       |
| Is authorization required for Additional Telehealth Benefits? | No       |
| Is a referral required for Additional Telehealth Benefits?    | No       |

**7k Opioid Treatment Program Services**

**Service Category Description**

**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Lab Services:                | \$0.00   |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 34   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |

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**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Is authorization required?                          | No   |
| Is a referral required for Transportation Services? | No   |
| Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |

**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?               | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

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

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**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

| <b>Question</b>            | <b>Response</b>   |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>  | <b>Response</b>   |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

| Question  | Response             |
|---|----------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every Year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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**13a Acupuncture**

Service Category Description

Benefit Description

**Question**

**Response**

**13b Over-the-Counter (OTC) Items**

Service Category Description

Benefit Description

**Question**

**Response**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

No

**13c Meal Benefit**

Service Category Description

Benefit Description

**Question**

**Response**

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

No

**13d Other 1**

Service Category Description

Benefit Description

**Question**

**Response**

**13e Other 2**

Service Category Description

Benefit Description

**Question**

**Response**

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13f Other 3

|                 |   |                 |
|-----------------|---|-----------------|
| <b>Question</b> | <b>Service Category Description</b><br><b>Benefit Description</b> | <b>Response</b> |
|-----------------|---|-----------------|

|                 |  |                 |
|-----------------|--|-----------------|
| <b>Question</b> | <b>13g Dual Eligible SNPs with Highly Integrated Services</b><br><b>Service Category Description</b><br><b>Benefit Description</b> | <b>Response</b> |
|-----------------|--|-----------------|

|                 |   |                 |
|-----------------|---|-----------------|
| <b>Question</b> | <b>13i Non-Primarily Health Related Benefits for the Chronically III</b><br><b>Service Category Description</b><br><b>Benefit Description</b> | <b>Response</b> |
|-----------------|---|-----------------|

|  |  |   |
|--|--|---|
| <b>Question</b>  | <b>14a Medicare-covered Zero Cost-Sharing Preventive Services</b><br><b>Service Category Description</b><br><b>Benefit Description</b> | <b>Response</b>   |
| 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  |

|                 |  |                 |
|-----------------|--|-----------------|
| <b>Question</b> | <b>14a Medicare-covered Zero Cost-Sharing Preventive Services</b><br><b>Service Category Description</b><br><b>Benefit Description</b> | <b>Response</b> |
|-----------------|--|-----------------|

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**14b Annual Physical Exam**  
**Service Category Description**  
**Benefit Description**

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

**14c Other Defined Supplemental Benefits**  
**Service Category Description**  
**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?                                | Yes  |
| Select enhanced benefit (Select all that apply):  | 14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c4: Fitness Benefit*; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c17: Alternative Therapies*; 14c18: Therapeutic Massage |
| Select type of benefit for Health Education:  | Mandatory  |
| Select type of benefit for Nutritional/Dietary Benefit:   | Mandatory  |
| Is this benefit unlimited for Nutritional/Dietary Benefit?  | No, indicate number  |
| Indicate number of visits for Nutritional/Dietary Benefit:  | 6  |
| 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 Technologies (including Web/Phone-based technologies and Nursing Hotline): | Mandatory  |
| Select the type of Remote Access Technologies offered (Select all that apply):                                      | Web/Phone-based technologies; Nursing Hotline  |
| Select type of benefit for Alternative Therapies:   | Mandatory  |
| Is this benefit unlimited for Alternative Therapies?  | No, indicate number  |
| Indicate number of visits offered for Alternative Therapies:  | 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   |

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14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

| Question  | Response   |
|---|--|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Deductible?  | No   |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00   |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00   |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00   |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00   |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00   |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00   |
| Indicate Minimum Copayment amount for Alternative Therapies:  | \$0.00   |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00   |
| Is authorization required?  | No   |
| Is a referral required for Other Defined Supplemental Benefits?   | No   |
| Nutritional/Dietary Benefit Notes:  | Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions, Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle. |
| Fitness Benefit 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. Nursing Hotline.  |
| 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. Nursing Hotline.  |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline.  |
| 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.  |

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**14d Kidney Disease Education Services**

**Service Category Description  
Benefit Description**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description  
Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is authorization required for Medicare-covered Digital Rectal Exams?        | No       |
| Is authorization required for Medicare-covered EKG following Welcome Visit? | No       |
| Is a referral required for any Services?                                    | No       |

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Attestation:   | I attest that the MA enrollee cost sharing for a Part B-rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B-rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug. |
| Is there a Maximum Enrollee Out-of-Pocket Cost?  | No  |
| Is there an enrollee Coinsurance?  | No  |
| Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:                      | 0%  |
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:   | 0%  |
| Is there an enrollee Copayment?  | No  |
| Is there an enrollee Coinsurance for Insulin?  | No  |
| Is there an enrollee Copayment for Insulin?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is Authorization Required?   | Yes   |
| Does the plan offer step therapy?  | Yes   |
| Does the benefit step from (select all that apply):  | Part B to Part B?, Part D to Part B?  |
| Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit? | No  |

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

**Service Category Description**

**Benefit Description**

**Question**

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

**Response**

No

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

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

Yes

Select enhanced benefits:

Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics; Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine Services?

Yes

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic Services?

No, indicate number

Indicate number of visits for Diagnostic Services:

1

Select the Diagnostic Services periodicity:

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

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

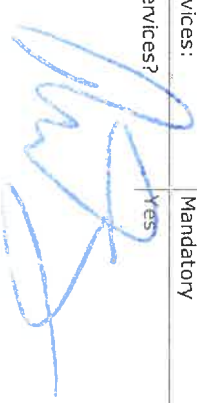
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?

Yes

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

**Service Category Description**

**Benefit Description**

| Question  | Response                         |
|---|----------------------------------|
| Is 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:  | 4500.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description  
Benefit Description**

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

**17b Eyewear**

**Service Category Description  
Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes  |
| Select type of benefit for Eyeglass lenses:                               | Mandatory  |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes  |
| Select type of benefit for Eyeglass frames:                               | Mandatory  |
| Is this benefit unlimited for Eyeglass frames?                            | Yes  |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes  |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period   |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes  |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 1000.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Deductible?  | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00   |
| Is authorization required?  | No   |
| Is a referral required for Eyewear?                                       | No   |
| Notes:  | Eyewear benefit maximum amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. |

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**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |
| Select type of benefit for Routine Hearing Exams:                           | Mandatory   |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every Year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every Year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response                 |
|--|--------------------------|
| 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                |

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| 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   |
| 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? | Per ear  |
| Select the Maximum Plan Benefit Coverage type:   | Plan-specified amount per period   |
| Indicate Maximum Plan Benefit Coverage amount:   | 1500.00  |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every Year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. |

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

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**19a Reduced Cost Sharing for VBID/UF/SSBCI**

| Question  | Response  |
|---|---|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?  | No  |
| Do you offer Special Supplemental Benefits for the Chronically Ill?   | No  |
| Are you offering a VBID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)                            | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?   | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (choose one or more):  | Annual Wellness Visit; Medicare Health Risk Assessment  |
| WHP Mode of Engagement (choose one or more):  | Telephonic; In-Person; Web-Based  |
| Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?  | No  |
| Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?  | No  |
| Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.         | Provider/Patient portals  |
| Expected Number of Beneficiaries to be Engaged Annually:  | 26650   |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                          | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:  | Analytics Tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening. Other, Describe  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:  | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.  |
| Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

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**19b Additional Benefits for VBID/UF/SSBCI**

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

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                              | Question   | Response  |
|-------------|---------------------------------------|--|---|
| 19b         | Additional Benefits for VBID/UF/SSBCI | Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?                                | VBID  |
|             |                                       | Targeting Methodology - Please choose one or both:<br>Select LIS reduction level:                        | Socioeconomic Status  |
|             |                                       | Expected Number of Enrollees to be Targeted:   | Dual-Eligible Status (for territories)  |
|             |                                       | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 26650   |
|             |                                       | Does the enrollee need to have all diseases selected to qualify?   | No  |
|             |                                       | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No  |
|             |                                       | Is there a prerequisite for any additional benefits for this package?                                    | No  |
|             |                                       | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 13110: General Supports for Living; 1311: Food and Produce; 1313: Pest Control; 1314: Transportation for Non-Medical Needs; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-O1: Other 1 Non-Primarily Health Related Benefit; 131-O2: Other 2 Non-Primarily Health Related Benefit; 131-O3: Other 3 Non-Primarily Health Related Benefit; 131-O4: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit |
|             |                                       | Are any benefits exempt from the plan-level deductible?  | No  |
|             |                                       | Is there a package level maximum coverage amount?  | No  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | A VBID Benefits Card can be used towards Food & Produce, indoor air quality equipment and services, social needs, complementary therapies, services supporting self-direction, some General Supports for Living, pet care supplies and memory fitness items. A separate benefit is offered where the member may choose 3 visits per quarter (12 visits annually) for home assistance services filed under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The remaining benefit is Transportation for Non-Medical Needs. |
|             |   | Does the plan provide Food and Produce as a supplemental benefit under Part C?                           | Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living   |
|             |   | Select type of benefit for Food and Produce:   | Yes   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | Mandatory   |
|             |   | Indicate Maximum Plan Benefit Coverage amount:   | Yes   |
|             |   | Select Maximum Plan Benefit Coverage periodicity:  | 80.00   |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | Every month   |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Food and Produce?   | No  |
|             |   | Notes:   | Benefit is covered through the VBID Benefits Card. Card balance rolls over to the following month.  |
|             |   | Does the plan provide Pest Control as a supplemental benefit under Part C?                               | Yes   |
|             |   | Select type of benefit for Pest Control:   | Mandatory   |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                  | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                   | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Pest Control?   | No   |
|             |          | Notes:   | Member will choose up to three (3) services per quarter (12 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? | Yes  |
|             |          | 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?                          | No   |
|             |          | Indicate number of trips for Plan-approved Location:   | 0  |
|             |          | Select Plan-approved Location Trips periodicity:   | Every year   |
|             |          | 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:                     | Van; Medical Transport   |
|             |          | Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is this benefit unlimited for number of trips for Any Location?                                    | No   |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13/4 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?              | No  |
|             |          | Notes:   | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Yes   |
|             |          | Select type of benefit for Social Needs Benefit:                                   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                  | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                                     | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                  | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Social Needs Benefit?                                   | No  |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  |  |
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C?               | Yes  |
|             |          | Select type of benefit for Complementary Therapies:   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                   | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:<br>Select Maximum Plan Benefit Coverage periodicity: | 0.00<br>Every month<br>ADMINISTRACION DE<br>SEGUROS DE SALUD   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                    | No<br>\$24 - 0004  |
|             |          | 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 Complementary Therapies?   | No   |
|             |          | Notes:  | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). |

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**19b Additional Benefits for VBIID/UF/SSBCT - VBIID Package 1**

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response    |
|-------------|----------|---|-------------|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?  | Yes         |
|             |          | Select type of benefit for Services Supporting Self-Direction:  | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?   | Yes         |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00        |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No          |
|             |          | Is there an enrollee Coinsurance?   | No          |
|             |          | Is there an enrollee Deductible?  | No          |
|             |          | Is there an enrollee Copayment?   | No          |
|             |          | Is authorization required?  | No          |
|             |          | Is a referral required for Services Supporting Self-Direction?  | No          |
|             |          | Notes:<br>Services supporting self-direction are covered through the VBIID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |             |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?   | Yes         |
|             |          | Select type of benefit for General Supports for Living:   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?   | No          |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No          |
|             |          | Is there an enrollee Coinsurance?   | No          |
|             |          | Is there an enrollee Deductible?  | No          |
|             |          | Is there an enrollee Copayment?   | No          |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category  | Question   | Response   |
|-------------|---|--|--|
|             |   | Is authorization required?   | No   |
|             |   | Is a referral required for General Supports for Living?  | No   |
|             |   | Notes:   | Member may choose up to three (3) services per quarter (12 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. |
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCT - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Other 1; Other 2; Other 3; Other 4   |
|             |   | Enter name of Service:   | Home cleaning  |
|             |   | Select type of benefit for Other 1:  | Mandatory  |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | No   |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No   |
|             |   | Is there an enrollee Coinsurance?  | No   |
|             |   | Is there an enrollee Deductible?   | No   |
|             |   | Is there an enrollee Copayment?  | No   |
|             |   | Is authorization required?   | No   |
|             |   | Is a referral required for Other 1 Services?   | No   |
|             |   | Notes:   | Member may choose up to three (3) services per quarter (12 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.  |
|             |   | Enter name of Service:   | Pet care   |

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**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Select type of benefit for Other 2:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 2 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBID Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function  |
|             |          | Select type of benefit for Other 3:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 3 Services?                      | No   |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.  |

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# Bid Reports 2024

## BBP Part D Benefits Report

MCS ADVANTAGE, INC.  
 H5577 - 017  
 VBID: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically III: No  
 Part D Senior Savings Model: No

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|   |   |
|---|---|
| Region:   | New York  |
| Lead Marketing Region:  | New York  |
| Org. Marketing Name:  | MCS Classicare  |
| Plan Name:  | MCS Classicare Platino Progreso (HMO D-SNP)                           |
| Plan Geographic Name:   | Puerto Rico   |
| Status:   | Version 3 - Renewal - Successfully exported to desk review (06/06/23) |
| Plan Type:  | HMO   |
| Enrollee Type:  | Part A and Part B   |
| Number of Tiers:  |   |
| Part D Plan Premium:  | N/A   |
| Continuation Area Available:  | No  |
| Visitor/Travel Benefit Available:   | US - No   |
| Formulary:  | Yes, 00024446   |
| Part D Benefit:   | Yes, Defined Standard   |
| Special Needs Plan:   | Yes   |
| Special Needs Plan Type:  | Dual-Eligible   |
| Dual-Eligible SNP:  | Medicare non-zero dollar cost sharing plan                            |
| Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? | Yes   |
| Standard Bid For Section B:   | No  |
| Standard Bid For Section C:   | No  |
| Standard Bid For Section D:   | No  |

| Part D Benefit Data  |  |
|--|--|
| Benefit  | Plan Data  |
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  |  |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |

|  |   |
|--|---|
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.  |
| Indicate which tiers have insulin drugs (Select all that apply):                           |   |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | ADMINISTRACION DE SEGUROS DE SALUD \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | Nº 2 4 - 0 0 0 4 \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   | Contrato Número   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   | EMR   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00  |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:            | \$35.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:            | \$35.00   |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:            | \$35.00   |
| Vaccine Attestation:   | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold  |   |

| General Data   |           |
|--|-----------|
| Benefit  | Plan Data |
| All drugs on formulary available at extended days supply   | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill?              | Yes       |
| Standard Retail Cost-sharing, 1 Month =  | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =   | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =   | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =   | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =   | 90 Days   |
| Long Term Care Pharmacy, 1 Month =   | 31 Days   |
| NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold |           |

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

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Contrato Número

EMR

**Bid Reports 2024**

**Plan Service Area Report**

MCS ADVANTAGE, INC.  
 HSS77-017  
 UBID: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Pinalino Progreso (HMO D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Status: Version 3 - Renewal. Successfully exported to desk review (06/06/23)  
 HMO  
 Part A and Part B  
 S0.00  
 N/A  
 No  
 US - No  
 Yes, 0002/1446  
 Yes, Defined Standard  
 Yes  
 Dual-Eligible  
 (Medicare non-zero dollar cost sharing plan)  
 Yes  
 No  
 No  
 No

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| State       | County        | County Code | Employer-Only County? | Pending County? | Partial County? |
|-------------|---------------|-------------|-----------------------|-----------------|-----------------|
| Puerto Rico | Aguadilla     | 40070       | No                    | No              | No              |
| Puerto Rico | Aguadilla     | 40030       | No                    | No              | No              |
| Puerto Rico | Aguas Buenas  | 40040       | No                    | No              | No              |
| Puerto Rico | Aibonito      | 40050       | No                    | No              | No              |
| Puerto Rico | Amaro         | 40060       | No                    | No              | No              |
| Puerto Rico | Arecibo       | 40070       | No                    | No              | No              |
| Puerto Rico | Arroyo        | 40080       | No                    | No              | No              |
| Puerto Rico | Barranconeta  | 40090       | No                    | No              | No              |
| Puerto Rico | Barranconitas | 40100       | No                    | No              | No              |
| Puerto Rico | Bayamon       | 40110       | No                    | No              | No              |
| Puerto Rico | Cabo Rojo     | 40120       | No                    | No              | No              |
| Puerto Rico | Caguas        | 40130       | No                    | No              | No              |



|             |             |       |    |    |    |    |   |
|-------------|-------------|-------|----|----|----|----|---|
| Puerto Rico | Camry       | 40160 | No | No | No | No | Zipcode(s): 00627; 00670  |
| Puerto Rico | Camionetas  | 40125 | No | No | No | No | Zipcode(s): 00729; 00745  |
| Puerto Rico | Gratilla    | 40150 | No | No | No | No | Zipcode(s): 00979; 00981; 00982; 00983; 00984; 00985; 00986; 00987; 00988 |
| Puerto Rico | Ciano       | 40160 | No | No | No | No | Zipcode(s): 00962; 00963  |
| Puerto Rico | Concy       | 40170 | No | No | No | No | Zipcode(s): 00736; 00737  |
| Puerto Rico | Cuba        | 40180 | No | No | No | No | Zipcode(s): 00735; 00742  |
| Puerto Rico | Clarks      | 40190 | No | No | No | No | Zipcode(s): 00638   |
| Puerto Rico | Cifra       | 40200 | No | No | No | No | Zipcode(s): 00739   |
| Puerto Rico | Coamo       | 40210 | No | No | No | No | Zipcode(s): 00769   |
| Puerto Rico | Comerio     | 40230 | No | No | No | No | Zipcode(s): 00782   |
| Puerto Rico | Corozal     | 40230 | No | No | No | No | Zipcode(s): 00783   |
| Puerto Rico | Culebra     | 40240 | No | No | No | No | Zipcode(s): 00775   |
| Puerto Rico | Dorado      | 40250 | No | No | No | No | Zipcode(s): 00646   |
| Puerto Rico | Fajardo     | 40260 | No | No | No | No | Zipcode(s): 00738; 00740  |
| Puerto Rico | Florida     | 40265 | No | No | No | No | Zipcode(s): 00650   |
| Puerto Rico | Guánica     | 40270 | No | No | No | No | Zipcode(s): 00647; 00653  |
| Puerto Rico | Guayama     | 40280 | No | No | No | No | Zipcode(s): 00704; 00784; 00785   |
| Puerto Rico | Guayanilla  | 40290 | No | No | No | No | Zipcode(s): 00656; 00783  |
| Puerto Rico | Guaynabo    | 40300 | No | No | No | No | Zipcode(s): 00934; 00955; 00966; 00968; 00969; 00970; 00971               |
| Puerto Rico | Guiribo     | 40310 | No | No | No | No | Zipcode(s): 00778   |
| Puerto Rico | Hatillo     | 40320 | No | No | No | No | Zipcode(s): 00659   |
| Puerto Rico | Hormigueros | 40330 | No | No | No | No | Zipcode(s): 00660   |
| Puerto Rico | Huacabo     | 40340 | No | No | No | No | Zipcode(s): 00741; 00745; 00749; 00792                                    |
| Puerto Rico | Isabela     | 40350 | No | No | No | No | Zipcode(s): 00662   |
| Puerto Rico | Jayuya      | 40360 | No | No | No | No | Zipcode(s): 00664   |
| Puerto Rico | Juana Diaz  | 40370 | No | No | No | No | Zipcode(s): 00795   |

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|             |               |       |    |    |    |  |
|-------------|---------------|-------|----|----|----|--|
| Puerto Rico | Juncos        | 40380 | No | No | No | Zipcode(s): 00777  |
| Puerto Rico | Lajas         | 40390 | No | No | No | Zipcode(s): 00687  |
| Puerto Rico | Lares         | 40400 | No | No | No | Zipcode(s): 00631; 00659   |
| Puerto Rico | Las Marias    | 40410 | No | No | No | Zipcode(s): 00670  |
| Puerto Rico | Las Piedras   | 40520 | No | No | No | Zipcode(s): 00771  |
| Puerto Rico | Lora          | 40430 | No | No | No | Zipcode(s): 00772  |
| Puerto Rico | Luquillo      | 40440 | No | No | No | Zipcode(s): 00773  |
| Puerto Rico | Manati        | 40450 | No | No | No | Zipcode(s): 00674  |
| Puerto Rico | Manicao       | 40460 | No | No | No | Zipcode(s): 00606  |
| Puerto Rico | Manabao       | 40470 | No | No | No | Zipcode(s): 00707  |
| Puerto Rico | Mariquetia    | 40480 | No | No | No | Zipcode(s): 00680; 00681; 00682  |
| Puerto Rico | Moca          | 40490 | No | No | No | Zipcode(s): 00676  |
| Puerto Rico | Morovis       | 40500 | No | No | No | Zipcode(s): 00687  |
| Puerto Rico | Naguabo       | 40510 | No | No | No | Zipcode(s): 00718; 00744   |
| Puerto Rico | Naranjito     | 40520 | No | No | No | Zipcode(s): 00719  |
| Puerto Rico | Orocovis      | 40530 | No | No | No | Zipcode(s): 00720  |
| Puerto Rico | Pailitas      | 40540 | No | No | No | Zipcode(s): 00723  |
| Puerto Rico | Penuelas      | 40550 | No | No | No | Zipcode(s): 00624  |
| Puerto Rico | Ponce         | 40560 | No | No | No | Zipcode(s): 00715; 00716; 00717; 00718; 00730; 00731; 00732; 00733; 00734; 00780 |
| Puerto Rico | Quebradillas  | 40570 | No | No | No | Zipcode(s): 00678  |
| Puerto Rico | Rincon        | 40580 | No | No | No | Zipcode(s): 00677  |
| Puerto Rico | Rio Grande    | 40590 | No | No | No | Zipcode(s): 00721; 00745   |
| Puerto Rico | Sabana Grande | 40610 | No | No | No | Zipcode(s): 00637  |
| Puerto Rico | Salinas       | 40620 | No | No | No | Zipcode(s): 00704; 00751   |
| Puerto Rico | San German    | 40630 | No | No | No | Zipcode(s): 00636; 00683   |

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Contratación

|             |               |       |    |    |    |    |   |
|-------------|---------------|-------|----|----|----|----|---|
| Puerto Rico | San Juan      | 40640 | No | No | No | No | Zipcode(s): 00101, 00902, 00905, 00906, 00907, 00908, 00909, 00910, 00911, 00912, 00913, 00914, 00915, 00916, 00917, 00918, 00919, 00920, 00921, 00922, 00923, 00924, 00925, 00926, 00927, 00928, 00929, 00930, 00931, 00933, 00935, 00936, 00937, 00938, 00939, 00940, 00955, 00975, 00976, 00979, 00981 |
| Puerto Rico | San Lorenzo   | 40650 | No | No | No | No | Zipcode(s): 00754   |
| Puerto Rico | San Sebastian | 40660 | No | No | No | No | Zipcode(s): 00685   |
| Puerto Rico | Santa Isabel  | 40670 | No | No | No | No | Zipcode(s): 00757   |
| Puerto Rico | Toa Alta      | 40680 | No | No | No | No | Zipcode(s): 00583, 01954  |
| Puerto Rico | Toa Baja      | 40690 | No | No | No | No | Zipcode(s): 00589, 00950, 00951, 00952  |
| Puerto Rico | Trajillo Alto | 40700 | No | No | No | No | Zipcode(s): 00776, 00977, 00978   |
| Puerto Rico | Unido         | 40710 | No | No | No | No | Zipcode(s): 00611, 00641  |
| Puerto Rico | Vega Alta     | 40720 | No | No | No | No | Zipcode(s): 00692, 00694  |
| Puerto Rico | Vega Baja     | 40730 | No | No | No | No | Zipcode(s): 00693, 00694  |
| Puerto Rico | Vieques       | 40740 | No | No | No | No | Zipcode(s): 00765   |
| Puerto Rico | Villalba      | 40750 | No | No | No | No | Zipcode(s): 00766   |
| Puerto Rico | Yabucoa       | 40760 | No | No | No | No | Zipcode(s): 00767   |
| Puerto Rico | Yauco         | 40770 | No | No | No | No | Zipcode(s): 00598   |

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Contrato Número

**Bid Reports 2024**

**Plan Level Cost Shares and Limits Report**

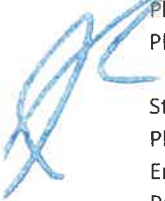
Contrato Número

MCS ADVANTAGE, INC.  
H5577 - 017  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No



EMR

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Progreso (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Version 3 - Renewal - Successfully exported to desk review (06/06/23)  
Status: HMO  
Plan Type: Part A and Part B  
Enrollee Type: \$0.00  
Part C Plan Premium: N/A  
Part D Plan Premium: No  
Continuation Area Available: US - No  
Visitor/Travel Benefit Available: Yes, 00024446  
Formulary: Yes, Defined Standard  
Part D Benefit: Yes  
Special Needs Plan: Dual-Eligible  
Special Needs Plan Type: Medicare non-zero dollar cost sharing plan  
Dual-Eligible SNP:



Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

| Plan Level Cost Shares and Limits  |                                      |
|--|--------------------------------------|
| Question   | Response                             |
| Is there an In-Network Plan Deductible?  | No                                   |
| 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 Lower, Intermediate or Mandatory Level? | Lower                                |
| 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 |

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|  |  |                        |
|--|--|------------------------|
| Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?                                  | Yes  | <b>Contrato Número</b> |
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |                        |
| Select the benefits that apply to the Maximum Enrollee Out-of-Pocket cost:   | Non-Medicare-covered benefits  |                        |

| Reductions in Cost Sharing - General     |          |
|--|----------|
| Question                                 | Response |
| Do you offer Reductions in Cost Sharing? | No       |

| Combined Benefits - General  |   |
|--|---|
| Question   | Response  |
| Do you offer Combined Supplemental Benefits?   | Yes   |
| Select the number of Combined Supplemental Benefit packages you are offering?  | 1   |
| Combined Benefits Group 1 Name:  | Combined Transportation   |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBID/UF/SSBCI |
| What is your combined supplemental benefits mode of delivery?  | Other   |
| Other Description:   | Transportation provided by contracted vendors.  |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No  |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No  |
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | Yes   |

|   |            |
|---|------------|
| Indicate number of shared visits/trips: | 34         |
| Select visit/trip limit periodicity:    | Every year |

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Contrato Número



**H5577 – 017 MCS Classicare Platino Progreso (HMO D-SNP)  
Buydown 2024**

**I. General Information**

|                     |       |                       |   |                            |     |                  |
|---------------------|-------|-----------------------|---|----------------------------|-----|------------------|
| 1. Contract Number: | H5577 | 5. Organization Name: | MCS ADVANTAGE, INC.                         | 9. Enrollee Type:          | A/B | 13. Region Name: |
| 2. Plan ID:         | 017   | 6. Plan Name:         | MCS Classicare Platino Progreso (HMO D-SNP) | 10. MA Region:             | N/A |                  |
| 3. Segment ID:      | 000   | 7. Plan Type:         | HMO   | 11. Act. Swap/Equiv Apply: | N   |                  |
| 4. Contract Year:   | 2024  | 8. MA-PD:             | Y   | 12. SNP:                   | Y   | 14. SNP Type:    |

**II. Other Information**

**A. Part B Information**

1. Maximum Pt B premium buydown amt., per CMS \$164.90

**B. Rebate Allocation for Part B Premium**

- 1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90) \$45.00
- 2. Part B Rebate Allocation, rounded to one decimal (see instructions) \$45.00




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# Appendix C-1

## Plan Benefit Package (PBP)

### H5577 – 029

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 029

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Region:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Segment ID:

Segment Geographic Name:

Status:

Plan Type:

Enrollee Type:

Part C Plan Premium:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

Part D Benefit:

Special Needs Plan:

Special Needs Plan Type:

Dual-Eligible SNP:

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Standard Bid For Section B:

Standard Bid For Section C:

Standard Bid For Section D:

New York  
New York

MCS Classicare

MCS Classicare Platino MasCash (HMO D-SNP)

Puerto Rico

0

null

Version 4 - Renewal - Successfully exported to desk review (06/06/23)

HMO

Part A and Part B

\$0.00

N/A

No

US - No

Yes, 00024446

Yes, Defined Standard

Yes

Dual-Eligible

Medicare non-zero dollar cost sharing plan

Yes

No

No

No

### Plan Level Data

Question

Response

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Contrato Número

**Tiered Cost sharing for Part B Services**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**  
**Benefit Description**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**  
**Benefit Description**

|  |                          |
|--|--------------------------|
| <b>Question</b>                          | <b>Response</b>          |
| <b>1b Inpatient Hospital-Psychiatric</b> | <b>ADMINISTRACION DE</b> |
| <b>Service Category Description</b>      | <b>SEGUROS DE SALUD</b>  |
| <b>Benefit Description</b>               | <b>Nº 2 4 - 0 0 0 4</b>  |

**Question**

|   |    |
|---|----|
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No |

**Contrato Numero**

*EMR*

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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Contrato Número

EMR

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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



**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

\$0.00

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary Rehabilitation Services?

No

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

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



**4c Worldwide Emergency/Urgent Coverage**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Partial Hospitalization?

No

**6 Home Health Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Home Health Services?

Yes

**7a Primary Care Physician Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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**7b Chiropractic Services**  
**Service Category Description**  
**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every Year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**  
**Service Category Description**  
**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

**Benefit Description**

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

**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

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**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Is there an enrollee Copayment?

No

Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:

\$0.00

Indicate Minimum Copayment amount for Medicare-covered Group Sessions:

\$0.00

Indicate Maximum Copayment amount for Medicare-covered Group Sessions:

\$0.00

Is authorization required?

No

Is a referral required for Psychiatric Services?

No

Notes:

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

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

No

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

Yes

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

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

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

**7k Opioid Treatment Program Services**

**Service Category Description**

**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |
| Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:    | \$0.00   |
| Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:    | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:           | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:           | \$0.00   |
| Is authorization required for non-emergency Medicare services?                           | Yes  |
| <b>10b Transportation Services</b>   |  |
| <b>Service Category Description</b>  |  |
| <b>Benefit Description</b>   |  |
| <b>Question</b>  | <b>Response</b>  |
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 32   |
| Select Plan Approved Health-related Location periodicity:                                | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |

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| 10b Transportation Services                         |  |
|---|--|
| Service Category Description                        |  |
| Benefit Description                                 |  |
| Question  | Response   |
| Is authorization required?                          | No   |
| Is a referral required for Transportation Services? | No   |
| Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |

| 11a Durable Medical Equipment (DME)  |   |
|--|---|
| Service Category Description   |   |
| Benefit Description  |   |
| Question   | Response  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?               | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

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**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**



| Question                   | Response  |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

|   |                      |
|---|----------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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|   |                 |
|---|-----------------|
| <b>13a Acupuncture</b>  |                 |
| <b>Service Category Description</b>   |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |
| <b>13b Over-the-Counter (OTC) Items</b>   |                 |
| <b>Service Category Description</b>   |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |
| Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?  |                 |
|   | No              |
| <b>13c Meal Benefit</b>   |                 |
| <b>Service Category Description</b>   |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |
| 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              |
| <b>13d Other 1</b>  |                 |
| <b>Service Category Description</b>   |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |
| <b>13e Other 2</b>  |                 |
| <b>Service Category Description</b>   |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |

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13f Other 3

Service Category Description

Benefit Description

Question

Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question

Response

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

Service Category Description

Benefit Description

Question

Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question

Response

Medicare-covered Zero Dollar Preventive Services Attestation

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

Is authorization required?

No

Is a referral required?

No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question

Response

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**14b Annual Physical Exam**

**Service Category Description**

**Benefit Description**

**Question**

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

**Response**

No

**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

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

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

6

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 Technologies (including Web/Phone-based technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies offered (Select all that apply):

Web/Phone-based technologies; Nursing Hotline

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative Therapies?

No, indicate number

Indicate number of visits offered for Alternative Therapies:

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

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**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00  |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00  |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Alternative Therapies:  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Other Defined Supplemental Benefits?   | No  |
| 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.  |
| 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. Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline. |
| 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.   |

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**14d Kidney Disease Education Services**

**Service Category Description**

**Benefit Description**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

|   |    |
|---|----|
| Is authorization required for Medicare-covered Digital Rectal Exams?        | No |
| Is authorization required for Medicare-covered EKG following Welcome Visit? | No |
| Is a referral required for any Services?                                    | No |

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

|  |   |
|--|---|
| Attestation:   | I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug. |
| Is there a Maximum Enrollee Out-of-Pocket Cost?  | No  |
| Is there an enrollee Coinsurance?  | No  |
| Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:                      | 0%  |
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:   | 0%  |
| Is there an enrollee Copayment?  | No  |
| Is there an enrollee Coinsurance for Insulin?  | No  |
| Is there an enrollee Copayment for Insulin?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is Authorization Required?   | Yes   |
| Does the plan offer step therapy?  | Yes   |
| Does the benefit step from (select all that apply):  | Part B to Part B?; Part D to Part B?  |
| Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit? | No  |

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

**Service Category Description**

**Benefit Description**



| <b>Question</b>   | <b>Response</b> |
|---|-----------------|
| Does the plan provide Preventive Dental Items as a supplemental benefit under Part C? | No              |

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>   | <b>Response</b>   |
|---|---|
| Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?        | Yes   |
| Select enhanced benefits:   | Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics; Other Oral/Maxillofacial Surgery, Other Services |
| Select type of benefit for Non-routine Services:  | Mandatory   |
| Is this benefit unlimited for Non-routine Services?   | Yes   |
| Select type of benefit for Diagnostic Services:   | Mandatory   |
| Is this benefit unlimited for Diagnostic Services?  | No, indicate number   |
| Indicate number of visits for Diagnostic Services:  | 1   |
| Select the Diagnostic Services periodicity:   | 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   |
| 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 Oral/Maxillofacial Surgery, Other Services? | Yes   |

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

**Service Category Description**

**Benefit Description**

| Question  | Response                         |
|---|----------------------------------|
| Is 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:  | 2400.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every Year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description**

**Benefit Description**

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

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| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

17b Eyewear

Service Category Description

Benefit Description

| Question  | Response  |
|---|---|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes   |
| Select type of benefit for Eyeglass lenses:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes   |
| Select type of benefit for Eyeglass frames:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass frames?                            | Yes   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes   |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period  |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes   |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 500.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Eyewear?                                       | No  |
| Notes:  | Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. |

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18a Hearing Exams

Service Category Description

Benefit Description

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Select type of benefit for Routine Hearing Exams:                         | Mandatory           |
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

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

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**18b Hearing Aids**

**Service Category Description**  
**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Hearing Aids (all types):                                   | Mandatory  |
| Is this benefit unlimited for Hearing Aids (all types)?                                | No, indicate number  |
| Indicate quantity for Hearing Aids (all types):  | 2  |
| Select Hearing Aids (all types) periodicity:   | Every year   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                      | 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:   | 500.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

**Response**

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

**Service Category Description**

**Benefit Description**

**Response**

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**19a Reduced Cost Sharing for VBIID/UF/SSBCI**

| Question   | Response  |
|--|---|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?   | No  |
| Do you offer Special Supplemental Benefits for the Chronically Ill?  | No  |
| Are you offering a VBIID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBIID Model? (VBIID Part D Rewards and Incentives programs should be entered in Section Rx)                           | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?  | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (Choose one or more):   | Annual Wellness Visit; Medicare Health Risk Assessment  |
| WHP Mode of Engagement (choose one or more):   | Telephonic; In-Person; Web-Based  |
| Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?   | No  |
| Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?   | No  |
| Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.          | Provider/Patient portals  |
| Expected Number of Beneficiaries to be Engaged Annually:   | 22965   |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                           | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBIID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:   | Analytics tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening. Other, Describe  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBIID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:   | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff   |
| Does your VBIID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

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**19b Additional Benefits for VBID/UF/SSBCI**

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

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                              | Question   | Response  |
|-------------|---------------------------------------|--|---|
| 19b         | Additional Benefits for VBID/UF/SSBCI | Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?                                | VBID  |
|             |                                       | Targeting Methodology - Please choose one or both:<br>Select LIS reduction level:                        | Socioeconomic Status<br>Dual-Eligible Status (for territories)  |
|             |                                       | Expected Number of Enrollees to be Targeted:   | 22965   |
|             |                                       | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 22965   |
|             |                                       | Does the enrollee need to have all diseases selected to qualify?   | No  |
|             |                                       | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No  |
|             |                                       | Is there a prerequisite for any additional benefits for this package?                                    | No  |
|             |                                       | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 1314: Transportation for Non-Medical Needs; 13110: General Supports for Living; 1311: Food and Produce; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-01: Other 1 Non-Primarily Health Related Benefit; 131-02: Other 2 Non-Primarily Health Related Benefit; 131-03: Other 3 Non-Primarily Health Related Benefit; 131-04: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit; 1313: Pest Control |
|             |                                       | Are any benefits exempt from the plan-level deductible?  | No  |
|             |                                       | Is there a package level maximum coverage amount?  | No  |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**  
**Disease States:**  
**Service Category Description**  
**Benefit Description**

| PPB Section | Category  | Question   | Response  |
|-------------|---|--|---|
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCT - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living |
|             |   | Does the plan provide Food and Produce as a supplemental benefit under Part C?                           | Yes   |
|             |   | Select type of benefit for Food and Produce:   | Mandatory   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | Yes   |
|             |   | Indicate Maximum Plan Benefit Coverage amount:   | 60.00   |
|             |   | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Food and Produce?   | No  |
|             |   | Notes:   | Maximum Plan Benefit Coverage amount on VBID Benefits Card does not carry forward to the next period if it is unused.   |
|             |   | Does the plan provide Pest Control as a supplemental benefit under Part C?                               | Yes   |
|             |   | Select type of benefit for Pest Control:   | Mandatory   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                  | No   |
|             |          | Is there a service-specific Maximum Employee Out-of-Pocket Cost?                                   | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Pest Control?   | No   |
|             |          | Notes:   | Member will choose up to three (3) services per quarter (12 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? | Yes  |
|             |          | 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?                          | No   |
|             |          | Indicate number of trips for Plan-approved Location:   | 0  |
|             |          | Select Plan-approved Location Trips periodicity:   | Every year   |
|             |          | 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:                     | Van; Medical Transport   |
|             |          | Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is this benefit unlimited for number of trips for Any Location?                                    | No   |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select Type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?              | No  |
|             |          | Notes:   | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Yes   |
|             |          | Select type of benefit for Social Needs Benefit:                                   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                  | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                                     | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                  | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Social Needs Benefit?                                   | No  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.                           |
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Complementary Therapies:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                     | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                     | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                      | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Complementary Therapies?                                   | No   |
|             |          | Notes:  | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). |

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

Disease States:

Service Category Description

Benefit Description

| PPB Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Services Supporting Self-Direction?                                   | No   |
|             |          | Notes:   | Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?        | Yes  |
|             |          | Select type of benefit for General Supports for Living:  | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for General Supports for Living?  | No  |
|             |   | Notes:   | Member may choose up to three (3) services per quarter (12 visits annually) for Home Assistance such as plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil, Cell Phone Benefit - Cellular data plan to improve or maintain the health or overall function of the enrollee. |
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCT - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Other 1; Other 2; Other 3; Other 4  |
|             |   | Enter name of Service:   | Home cleaning   |
|             |   | Select type of benefit for Other 1:  | Mandatory   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | No  |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Other 1 Services?   | No  |
|             |   | Notes:   | Member may choose up to three (3) services per quarter (12 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.   |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Enter name of Service:  | Pet care   |
|             |          | Select type of benefit for Other 2:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 2 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBID Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function  |
|             |          | Select type of benefit for Other 3:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Is a referral required for Other 3 Services?                      | No   |
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.  |

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# Bid Reports 2024



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## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
H5577 - 029  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

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|   |   |
|---|---|
| Region:   | New York  |
| Lead Marketing Region:  | New York  |
| Org. Marketing Name:  | MCS Classicare  |
| Plan Name:  | MCS Classicare Platino MasCa\$h (HMO D-SNP)                           |
| Plan Geographic Name:   | Puerto Rico   |
| Status:   | Version 4 - Renewal - Successfully exported to desk review (06/06/23) |
| Plan Type:  | HMO   |
| Enrollee Type:  | Part A and Part B   |
| Number of Tiers:  |   |
| Part D Plan Premium:  | N/A   |
| Continuation Area Available:  | No  |
| Visitor/Travel Benefit Available:   | US - No   |
| Formulary:  | Yes, 00024446   |
| Part D Benefit:   | Yes, Defined Standard   |
| Special Needs Plan:   | Yes   |
| Special Needs Plan Type:  | Dual-Eligible   |
| Dual-Eligible SNP:  | Medicare non-zero dollar cost sharing plan                            |
| Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? | Yes   |
| Standard Bid For Section B:   | No  |
| Standard Bid For Section C:   | No  |
| Standard Bid For Section D:   | No  |

| Part D Benefit Data  |  |
|--|--|
| Benefit  | Plan Data  |
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  |  |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |

|  |   |          |
|--|---|----------|
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.  |          |
| Indicate which tiers have insulin drugs (Select all that apply):                           |   |          |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       |   | \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | ADMINISTRACION DE SEGUROS DE SALUD  | \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | Nº 24 - 0004  | \$105.00 |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   | Contrato Número   |          |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |   |          |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | EMR   | \$105.00 |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:            |   | \$35.00  |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:            |   | \$35.00  |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:            |   | \$35.00  |
| Vaccine Attestation:   | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |          |
| Cost Shares Above the Threshold  |   |          |

| General Data   |           |
|--|-----------|
| Benefit  | Plan Data |
| All drugs on formulary available at extended days supply   | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill?              | Yes       |
| Standard Retail Cost-sharing, 1 Month =  | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =   | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =   | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =   | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =   | 90 Days   |
| Long Term Care Pharmacy, 1 Month =   | 31 Days   |
| NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold |           |

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

Bid Reports 2024

Plan Service Area Report

MCSS ADMINSTRAGE, INC  
 H527-022  
 USB, Yes - Part C  
 ACA Uniformity Flexibility, No  
 Special Supplemental Benefits for non-Overseas R, No  
 Part D Senior Savings Model, No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCSS Classicare  
 Plan Name: MCSS Classicare (Medicare-Medicare) (HMO-D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Version: 3 - Recusal - Successfully expected to elect  
 version: 06/06/23  
 HMO: Part A and Part B  
 TO DO: No  
 Part B Plan Premium: No  
 Continuation Area Available: No  
 Visitor/Travel Benefits Available: US - No  
 Formulary: Yes, 00024445  
 Part D Benefits: Yes, Technical Standard  
 Special Needs Plan: No  
 Special Needs Plan Type: Dual Eligible SNP  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
 Under the D-SNP, has the state agency to open a dual-eligible  
 premium and cost sharing for enrollees in year: D-SNP?  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

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| State       | County       | County Code | En (In-Or) County? | Pending County? | Partial County? |
|-------------|--------------|-------------|--------------------|-----------------|-----------------|
| Puerto Rico | Aguadilla    | 49010       | No                 | No              | No              |
| Puerto Rico | Aguadilla    | 49020       | No                 | No              | No              |
| Puerto Rico | Aguadilla    | 49030       | No                 | No              | No              |
| Puerto Rico | Aguas Buenas | 49040       | No                 | No              | No              |
| Puerto Rico | Albany       | 49050       | No                 | No              | No              |
| Puerto Rico | Arroyo       | 49060       | No                 | No              | No              |
| Puerto Rico | Arroyo       | 49070       | No                 | No              | No              |
| Puerto Rico | Arroyo       | 49080       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49090       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49100       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49110       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49120       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49130       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49140       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49150       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49160       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49170       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49180       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49190       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49200       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49210       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49220       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49230       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49240       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49250       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49260       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49270       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49280       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49290       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49300       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49310       | No                 | No              | No              |
| Puerto Rico | Barranquitas | 49320       | No                 | No              | No              |

|             |               |       |    |    |  |
|-------------|---------------|-------|----|----|--|
| Puerto Rico | Hermosillo    | 40350 | No | No | No   |
| Puerto Rico | Hirundo       | 40340 | No | No | Zuscedis: 00662  |
| Puerto Rico | Indiana       | 40320 | No | No | Zuscedis: 00741, 00745, 01291, 00732   |
| Puerto Rico | Islaya        | 40360 | No | No | Zuscedis: 00562  |
| Puerto Rico | Isleña II. 2  | 40370 | No | No | Zuscedis: 00554  |
| Puerto Rico | Juncos        | 40380 | No | No | Zuscedis: 00755  |
| Puerto Rico | Juana         | 40390 | No | No | Zuscedis: 00777  |
| Puerto Rico | Juana         | 40400 | No | No | Zuscedis: 00607  |
| Puerto Rico | Las Marias    | 40410 | No | No | Zuscedis: 00611, 00616   |
| Puerto Rico | Las Piedras   | 40420 | No | No | Zuscedis: 00670  |
| Puerto Rico | Leiza         | 40430 | No | No | Zuscedis: 00771  |
| Puerto Rico | Lubero        | 40440 | No | No | Zuscedis: 00772  |
| Puerto Rico | Madriz        | 40450 | No | No | Zuscedis: 00773  |
| Puerto Rico | Maldonado     | 40460 | No | No | Zuscedis: 00674  |
| Puerto Rico | Maldonado     | 40470 | No | No | Zuscedis: 00626  |
| Puerto Rico | Milagros      | 40480 | No | No | Zuscedis: 00777  |
| Puerto Rico | Moca          | 40490 | No | No | Zuscedis: 00610, 00611, 00612  |
| Puerto Rico | Morones       | 40500 | No | No | Zuscedis: 00676  |
| Puerto Rico | Naguabo       | 40510 | No | No | Zuscedis: 00587  |
| Puerto Rico | Naranjo       | 40520 | No | No | Zuscedis: 00718, 00744   |
| Puerto Rico | Orocoba       | 40530 | No | No | Zuscedis: 00719  |
| Puerto Rico | Pajillas      | 40540 | No | No | Zuscedis: 00723  |
| Puerto Rico | Penuelas      | 40550 | No | No | Zuscedis: 00723  |
| Puerto Rico | Penuelas      | 40560 | No | No | Zuscedis: 00724  |
| Puerto Rico | Quebradillas  | 40570 | No | No | Zuscedis: 00715, 00716, 00717, 00718, 00730, 00731, 00732, 00733, 00734, 00735 |
| Puerto Rico | Rincon        | 40580 | No | No | Zuscedis: 00679  |
| Puerto Rico | Rio Grande    | 40590 | No | No | Zuscedis: 00677  |
| Puerto Rico | Sabana Grande | 40610 | No | No | Zuscedis: 00714, 00715   |
| Puerto Rico | Sajon         | 40620 | No | No | Zuscedis: 00677  |
| Puerto Rico | San German    | 40630 | No | No | Zuscedis: 00794, 00751   |
| Puerto Rico | San Juan      | 40640 | No | No | Zuscedis: 00677, 00681   |
| Puerto Rico | San Lorenzo   | 40650 | No | No | Zuscedis: 00754  |
| Puerto Rico | San Sebastian | 40660 | No | No | Zuscedis: 00681  |
| Puerto Rico | Santa Rosa    | 40670 | No | No | Zuscedis: 00717  |
| Puerto Rico | Santa Rosa    | 40680 | No | No | Zuscedis: 00552, 00553   |
| Puerto Rico | Santa Rosa    | 40690 | No | No | Zuscedis: 00613, 00650, 00791, 00792   |
| Puerto Rico | Santa Rosa    | 40700 | No | No | Zuscedis: 00776, 00777, 00778  |
| Puerto Rico | Santa Rosa    | 40710 | No | No | Zuscedis: 00611, 00612   |
| Puerto Rico | Santa Rosa    | 40720 | No | No | Zuscedis: 00727, 00728   |
| Puerto Rico | Santa Rosa    | 40730 | No | No | Zuscedis: 00611, 00612   |
| Puerto Rico | Santa Rosa    | 40740 | No | No | Zuscedis: 00715  |
| Puerto Rico | Santa Rosa    | 40750 | No | No | Zuscedis: 00728  |
| Puerto Rico | Santa Rosa    | 40760 | No | No | Zuscedis: 00728  |
| Puerto Rico | Santa Rosa    | 40770 | No | No | Zuscedis: 00728  |

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# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.  
 H5577 - 029  
 VBID: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Platino MasCa\$h (HMO D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Status: Version 4 - Renewal - Successfully exported to desk review (06/06/23)  
 Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$0.00  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 00024446  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Special Needs Plan Type: Dual-Eligible  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

| Plan Level Cost Shares and Limits  |                                      |
|--|--------------------------------------|
| Question   | Response                             |
| Is there an In-Network Plan Deductible?  | No                                   |
| 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 Lower, Intermediate or Mandatory Level? | Lower                                |
| 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 |

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|  |  |
|--|--|
| Does the In-Network Maximum Enrollee Out-of-Pocket Cost apply to all In-Network Medicare-covered plan services?                                  | Yes  |
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |

**Reductions in Cost Sharing - General**

| Question                                 | Response |
|--|----------|
| Do you offer Reductions in Cost Sharing? | No       |

**Combined Benefits - General**

| Question   | Response   |
|--|--|
| Do you offer Combined Supplemental Benefits?   | Yes  |
| Select the number of Combined Supplemental Benefit packages you are offering?  | 2  |
| Combined Benefits Group 1 Name:  | Combined Eyewear and Hearing   |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 500.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |

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|  |   |
|--|---|
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No  |
| Combined Benefits Group 2 Name:  | Combined Transportation   |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBID/UF/SSBCI |
| What is your combined supplemental benefits mode of delivery?  | Other   |
| Other Description:   | Transportation provided by contracted vendors.  |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No  |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No  |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes   |
| Indicate number of shared visits:  | 32  |
| Select visit limit periodicity:  | Every year  |

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SEGUROS DE SALUD

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**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                   |       |                     |   |                         |     |                |
|-------------------|-------|---------------------|---|-------------------------|-----|----------------|
| 1 Contract Number | H5577 | 5 Organization Name | MCS ADVANTAGE INC<br>MCS Classicare Platino MasCaSh (HMO D- | 9 Enrollee Type         | A/B | 13 Region Name |
| 2 Plan ID         | 029   | 6 Plan Name         | SNP)  | 10 MA Region            | N/A |                |
| 3 Segment ID      | 000   | 7 Plan Type         | HMO   | 11 Act Swap/Equiv Apply | N   |                |
| 4 Contract Year   | 2024  | 8 MA-PD             | Y   | 12 SNP                  | Y   | 14 SNP Type    |

**II. Other Information**

|   |          |  |          |
|---|----------|--|----------|
| <b>A. Part B Information</b>                |          | <b>B. Rebate Allocation for Part B Premium</b>                       |          |
| 1 Maximum Pt B premium buydown amt. per CMS | \$164.90 | 1 PMPM Rebate Allocation for Part B premium (maximum value=\$164.90) | \$164.90 |
|   |          | 2 Part B Rebate Allocation rounded to one decimal (see instructions) | \$164.90 |

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# Appendix C-1

## Plan Benefit Package (PBP)

### H5577 – 046

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 046

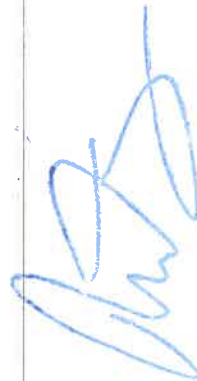

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically Ill: No

Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Total (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 0  
Segment Geographic Name: null  
Status: **Version 3 - Renewal - Successfully exported to desk review (06/06/23)**  
Plan Type: HMO  
Employee Type: Part A and Part B  
~~Part C Plan Premium: \$0.00~~  
~~Part B Plan Premium: N/A~~  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Special Needs Plan Type: Dual-Eligible  
Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

| Plan Level Data |   |
|-----------------|---|
| Question        | Response  |
|                 | ADMINISTRACION DE SEGUROS DE SALUD  |
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|                 | Contrato Número   |
|                 |  |
|                 |    |

**Tiered Cost sharing for Part B Services**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**

**Benefit Description**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No       |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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

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

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

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

| 3 Cardiac and Pulmonary Rehabilitation Services |                     |          |
|---|---------------------|----------|
| Service Category Description                    | Benefit Description | Response |
|   |                     |          |

| 4a Emergency Services  |                     |          |
|--|---------------------|----------|
| Service Category Description                                     | Benefit Description | Response |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? |                     | No       |
| Is there an enrollee Coinsurance?                                |                     | No       |
| Is there an enrollee Copayment?                                  |                     | No       |

| 4a Emergency Services        |                     |          |
|------------------------------|---------------------|----------|
| Service Category Description | Benefit Description | Response |
|                              |                     |          |

| 4b Urgently Needed Services  |                     |          |
|------------------------------|---------------------|----------|
| Service Category Description | Benefit Description | Response |
|                              |                     |          |

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

**Response**

Question  
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

**4c Worldwide Emergency/Urgent Coverage**

**Service Category Description**

**Benefit Description**

**Response**

Question  
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?

Yes

Select enhanced benefit:

Worldwide Emergency Coverage; Worldwide Urgent Coverage

Select type of benefit for Worldwide Emergency Coverage:

Mandatory

Select type of benefit for Worldwide Urgent Coverage:

Mandatory

Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?

No

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

Indicate Minimum Copayment amount for Worldwide Emergency Coverage:

\$0.00

Indicate Maximum Copayment amount for Worldwide Emergency Coverage:

\$0.00

Indicate Minimum Copayment amount for Worldwide Urgent Coverage:

\$0.00

Indicate Maximum Copayment amount for Worldwide Urgent Coverage:

\$0.00

Is there an enrollee Deductible?

No

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

Notes:

Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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**7b Chiropractic Services**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**

**Service Category Description**

**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

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

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**7f Podiatry Services**

**Service Category Description**

| Question            | Response     |
|---------------------|--------------|
| Benefit Description | No 24 - 0004 |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

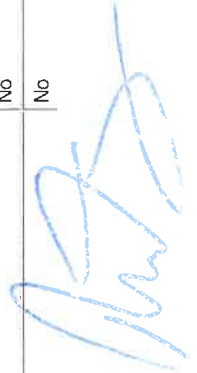
**Benefit Description**

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

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| 7h Psychiatric Services   |                     |          |
|---|---------------------|----------|
| Service Category Description  | Benefit Description | Response |
| Question  |                     |          |
| Is there an enrollee Copayment?   |                     | No       |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: |                     | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: |                     | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:      |                     | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:      |                     | \$0.00   |
| Is authorization required?  |                     | No       |
| Is a referral required for Psychiatric Services?                            |                     | No       |
| Notes:  |                     |          |
| Notes:  |                     |          |

| 7i Physical Therapy and Speech-Language Pathology Services                          |                     |          |
|---|---------------------|----------|
| Service Category Description  | Benefit Description | Response |
| Question  |                     |          |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    |                     | No       |
| Is there an enrollee Coinsurance?   |                     | No       |
| Is there an enrollee Deductible?  |                     | No       |
| Is there an enrollee Copayment?   |                     | No       |
| Is authorization required?  |                     | Yes      |
| Is a referral required for Physical Therapy and Speech-Language Pathology Services? |                     | No       |

| 7j Additional Telehealth Benefits                                  |                     |          |
|--|---------------------|----------|
| Service Category Description                                       | Benefit Description | Response |
| Question   |                     |          |
| Do you offer an Additional Telehealth benefit for Part B services? |                     | Yes      |

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

| 7k Opioid Treatment Program Services                             |                     |
|--|---------------------|
| Service Category Description                                     | Benefit Description |
| Question   | Response            |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | No                  |
| Is there an enrollee Coinsurance?                                | No                  |
| Is there an enrollee Deductible?                                 | No                  |
| Is there an enrollee Copayment?                                  | No                  |
| Is authorization required?                                       | No                  |
| Is a referral required for Opioid Treatment Program Services?    | No                  |

| 8a Outpatient Diagnostic Procedures, Tests and Lab Services      |                     |
|--|---------------------|
| Service Category Description                                     | Benefit Description |
| Question   | Response            |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | No                  |
| Is there an enrollee Coinsurance?                                | No                  |
| Is there an enrollee Deductible?                                 | No                  |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**9b Ambulatory Surgical Center (ASC) Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

**Response**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

**Response**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 24   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |

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| 10b Transportation Services                         |  |
|---|--|
| Service Category Description                        | Benefit Description  |
| Question  | Response   |
| Is authorization required?                          | No   |
| Is a referral required for Transportation Services? | No   |
| Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13/4 - Transportation for Non-Medical Needs. |

| 11a Durable Medical Equipment (DME)  |   |
|--|---|
| Service Category Description   | Benefit Description   |
| Question   | Response  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?               | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

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**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

| Question                   | Response  |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |



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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

| Question  | Response             |
|---|----------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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|                                     |  |                 |
|-------------------------------------|--|-----------------|
| <b>13a Acupuncture</b>              |  |                 |
| <b>Service Category Description</b> |  |                 |
| <b>Benefit Description</b>          |  | <b>Response</b> |
| <b>Question</b>                     |  |                 |

|   |  |                 |
|---|--|-----------------|
| <b>13b Over-the-Counter (OTC) Items</b> |  |                 |
| <b>Service Category Description</b>     |  |                 |
| <b>Benefit Description</b>              |  | <b>Response</b> |
| <b>Question</b>                         | Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C? | No              |

|                                     |   |                 |
|-------------------------------------|---|-----------------|
| <b>13c Meal Benefit</b>             |   |                 |
| <b>Service Category Description</b> |   |                 |
| <b>Benefit Description</b>          |   | <b>Response</b> |
| <b>Question</b>                     | 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              |

|                                     |  |                 |
|-------------------------------------|--|-----------------|
| <b>13d Other 1</b>                  |  |                 |
| <b>Service Category Description</b> |  |                 |
| <b>Benefit Description</b>          |  | <b>Response</b> |
| <b>Question</b>                     |  |                 |

|                                     |  |                 |
|-------------------------------------|--|-----------------|
| <b>13e Other 2</b>                  |  |                 |
| <b>Service Category Description</b> |  |                 |
| <b>Benefit Description</b>          |  | <b>Response</b> |
| <b>Question</b>                     |  |                 |

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|                                     |                 |
|-------------------------------------|-----------------|
| <b>13f Other 3</b>                  |                 |
| <b>Service Category Description</b> |                 |
| <b>Benefit Description</b>          |                 |
| <b>Question</b>                     | <b>Response</b> |

|   |                 |
|---|-----------------|
| <b>13g Dual Eligible SNPs with Highly Integrated Services</b> |                 |
| <b>Service Category Description</b>                           |                 |
| <b>Benefit Description</b>                                    |                 |
| <b>Question</b>   | <b>Response</b> |

|  |                 |
|--|-----------------|
| <b>13i Non-Primarily Health Related Benefits for the Chronically III</b> |                 |
| <b>Service Category Description</b>                                      |                 |
| <b>Benefit Description</b>   |                 |
| <b>Question</b>  | <b>Response</b> |

|   |   |
|---|---|
| <b>14a Medicare-covered Zero Cost-Sharing Preventive Services</b> |   |
| <b>Service Category Description</b>                               |   |
| <b>Benefit Description</b>  |   |
| <b>Question</b>   | <b>Response</b>   |
| 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  |

|   |                 |
|---|-----------------|
| <b>14a Medicare-covered Zero Cost-Sharing Preventive Services</b> |                 |
| <b>Service Category Description</b>                               |                 |
| <b>Benefit Description</b>  |                 |
| <b>Question</b>   | <b>Response</b> |

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|  |                 |
|--|-----------------|
| <b>14b Annual Physical Exam</b>  |                 |
| <b>Service Category Description</b>  |                 |
| <b>Benefit Description</b>   | <b>Response</b> |
| Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C? | No              |

|   |  |
|---|--|
| <b>14c Other Defined Supplemental Benefits</b>  |  |
| <b>Service Category Description</b>   |  |
| <b>Benefit Description</b>  | <b>Response</b>  |
| <b>Question</b>   | <b>Response</b>  |
| 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 |
| Select type of benefit for Health Education:  | Mandatory  |
| Select type of benefit for Nutritional/Dietary Benefit:   | Mandatory  |
| Is this benefit unlimited for Nutritional/Dietary Benefit?  | No, indicate number  |
| Indicate number of visits for Nutritional/Dietary Benefit:  | 6  |
| 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 Technologies (including Web/Phone-based technologies and Nursing Hotline): | Mandatory  |
| Select the type of Remote Access Technologies offered (Select all that apply):                                      | Web/Phone-based technologies; Nursing Hotline  |
| Select type of benefit for Alternative Therapies:   | Mandatory  |
| Is this benefit unlimited for Alternative Therapies?  | No, indicate number  |
| Indicate number of visits offered for Alternative Therapies:  | 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   |

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**14c Other Defined Supplemental Benefits**

**Service Category Description**

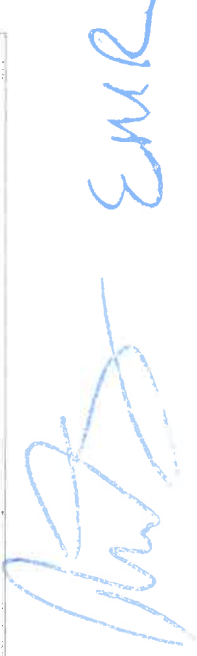
**Benefit Description**

| Question  | Response   |
|---|--|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Deductible?  | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00   |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00   |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00   |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00   |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00   |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00   |
| Indicate Minimum Copayment amount for Alternative Therapies:  | \$0.00   |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00   |
| Is authorization required?  | No   |
| Is a referral required for Other Defined Supplemental Benefits?   | No   |
| 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.   |
| 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.Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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.Nursing Hotline. |
| 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.  |

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**14d Kidney Disease Education Services**

**Service Category Description**

**Benefit Description**

**Response**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

**Response**

|   |        |                                    |
|---|--------|------------------------------------|
| <b>Question</b>   |        |                                    |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services? | No     |                                    |
| Is there an enrollee Coinsurance?   | No     |                                    |
| Is there an enrollee Deductible?  | No     |                                    |
| Is there an enrollee Copayment?   | No     |                                    |
| Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:                                      | \$0.00 |                                    |
| Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:                                      | \$0.00 |                                    |
| Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:                       | \$0.00 |                                    |
| Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:   | \$0.00 |                                    |
| Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:   | \$0.00 |                                    |
| Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:                                    | \$0.00 |                                    |
| Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:                                    | \$0.00 |                                    |
| Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:                             | \$0.00 |                                    |
| Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:                             | \$0.00 |                                    |
| Is authorization required for Medicare-covered Glaucoma Screening?  | No     | ADMINISTRACION DE SEGUROS DE SALUD |
| Is authorization required for Medicare-covered Diabetes Self-Management Training?                               | No     |                                    |
| Is authorization required for Medicare-covered Barium Enemas?   | No     |                                    |

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

**Response**

|   |  |    |
|---|--|----|
| <b>Question</b>   |  |    |
| Is authorization required for Medicare-covered Digital Rectal Exams?        |  | No |
| Is authorization required for Medicare-covered EKG following Welcome Visit? |  | No |
| Is a referral required for any Services?                                    |  | No |

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

**Response**

|  |  |   |
|--|--|---|
| <b>Question</b>  |  |   |
| Attestation:   |  | I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug. |
| Is there a Maximum Enrollee Out-of-Pocket Cost?  |  | No  |
| Is there an enrollee Coinsurance?  |  | No  |
| Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:                      |  | 0%  |
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:   |  | 0%  |
| Is there an enrollee Copayment?  |  | No  |
| Is there an enrollee Coinsurance for Insulin?  |  | No  |
| Is there an enrollee Copayment for Insulin?  |  | No  |
| Is there an enrollee Deductible?   |  | No  |
| Is Authorization Required?   |  | Yes   |
| Does the plan offer step therapy?  |  | Yes   |
| Does the benefit step from (select all that apply):  |  | Part B to Part B?; Part D to Part B?  |
| Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit? |  | No  |

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

**Service Category Description**

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

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

**Service Category Description**

| Question  | Benefit Description | Response  |
|---|---------------------|---|
| Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?        |                     | Yes   |
| Select enhanced benefits:   |                     | Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services |
| Select type of benefit for Non-routine Services:  |                     | Mandatory   |
| Is this benefit unlimited for Non-routine Services?   |                     | Yes   |
| Select type of benefit for Diagnostic Services:   |                     | Mandatory   |
| Is this benefit unlimited for Diagnostic Services?  |                     | No, indicate number   |
| Indicate number of visits for Diagnostic Services:  |                     | 1   |
| Select the Diagnostic Services periodicity:   |                     | 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   |
| 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 Oral/Maxillofacial Surgery, Other Services? |                     | Yes   |

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

| Question  | Response                         |
|---|----------------------------------|
| 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:  | 1200.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description**

**Benefit Description**

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

**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes  |
| Select type of benefit for Eyeglass lenses:                               | Mandatory  |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes  |
| Select type of benefit for Eyeglass frames:                               | Mandatory  |
| Is this benefit unlimited for Eyeglass frames?                            | Yes  |
| 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:                   | 700.00   |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Deductible?  | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00   |
| Is authorization required?  | No   |
| Is a referral required for Eyewear?                                       | No   |
| Notes:  | <p>Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.</p> <p>ADMINISTRACION DE SEGUROS DE SALUD</p> <p>024 - 0004</p> <p>Contrato Número <i>EMR</i></p> |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Select type of benefit for Routine Hearing Exams:                         | Mandatory           |
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

|   |  |
|---|--|
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|---|--|

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

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

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Hearing Aids (all types):                                   | Mandatory  |
| Is this benefit unlimited for Hearing Aids (all types)?                                | No, indicate number  |
| Indicate quantity for Hearing Aids (all types):  | 2  |
| Select Hearing Aids (all types) periodicity:   | Every year   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                      | 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:   | 700.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

| Question  | Response                           |
|---|------------------------------------|
| 20 Outpatient Drugs and Biologicals/Prescription Drugs /Home Infusion Drugs | ADMINISTRACION DE SEGUROS DE SALUD |
| Service Category Description  | № 2 4 - 0 0 0 4                    |
| Benefit Description   |                                    |
| Question  | Response                           |

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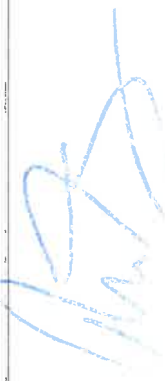
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**19a Reduced Cost Sharing for VBID/UF/SSBCI**

| Question  | Response  |
|---|---|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?  | No  |
| Do you offer Special Supplemental Benefits for the Chronically Ill?   | No  |
| Are you offering a VBID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)                            | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?   | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (Choose one or more):  | Annual Wellness Visit; Medicare Health Risk Assessment  |
| WHP Mode of Engagement (choose one or more):  | Telephonic; In-Person; Web-Based  |
| Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?  | No  |
| Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?  | No  |
| Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.         | Provider/Patient portals  |
| Expected Number of Beneficiaries to be Engaged Annually:  | 23641   |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                          | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:  | Analytics tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening.  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:  | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.  |
| Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

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**19b Additional Benefits for VBID/UF/SSBCI**

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

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                              | Question   | Response   |
|-------------|---------------------------------------|--|--|
| 19b         | Additional Benefits for VBID/UF/SSBCI | Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?                                | VBID   |
|             |                                       | Targeting Methodology - Please choose one or both:<br>Select LIS reduction level:                        | Socioeconomic Status<br>Dual-Eligible Status (for territories)   |
|             |                                       | Expected Number of Enrollees to be Targeted:   | 23641  |
|             |                                       | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 23641  |
|             |                                       | Does the enrollee need to have all diseases selected to qualify?   | No   |
|             |                                       | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No   |
|             |                                       | Is there a prerequisite for any additional benefits for this package?                                    | No   |
|             |                                       | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 13i10: General Supports for Living; 13i11: Food and Produce; 13i3: Pest Control; 13i4: Transportation for Non-Medical Needs; 13i5: Indoor Air Quality Equipment and Services; 13i6: Social Needs Benefit; 13i7: Complementary Therapies; 13i8: Services Supporting Self-Direction; 13i-O1: Other 1 Non-Primarily Health Related Benefit; 13i-O2: Other 2 Non-Primarily Health Related Benefit; 13i-O3: Other 3 Non-Primarily Health Related Benefit; 13i-O4: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit |
|             |                                       | Are any benefits exempt from the plan-level deductible?  | No   |
|             |                                       | Is there a package level maximum coverage amount?  | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response   |
|-------------|---|--|--|
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Notes:<br><br>Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:<br><br>Does the plan provide Food and Produce as a supplemental benefit under Part C?<br><br>Select type of benefit for Food and Produce:<br><br>Is there a service-specific Maximum Plan Benefit Coverage amount?<br><br>Indicate Maximum Plan Benefit Coverage amount:<br><br>Select Maximum Plan Benefit Coverage periodicity:<br><br>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?<br><br>Is there an enrollee Coinsurance?<br><br>Is there an enrollee Deductible?<br><br>Is there an enrollee Copayment?<br><br>Is authorization required?<br><br>Is a referral required for Food and Produce?<br><br>Notes:<br><br>Does the plan provide Pest Control as a supplemental benefit under Part C?<br><br>Select type of benefit for Pest Control: | A VBID Benefits Card can be used towards Food & Produce, indoor air quality equipment and services, social needs, complementary therapies, services supporting self-direction, some General Supports for Living, pet care supplies and memory fitness items. A separate benefit is offered where the member may choose 3 visits per quarter (12 visits annually) for home assistance services filed under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The third benefit is Transportation for Non-Medical Needs.<br><br>Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living<br><br>Yes<br><br>Mandatory<br><br>Yes<br><br>250.00<br><br>Every month<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.<br><br>Yes<br><br>Mandatory |

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**19b Additional Benefits for VBID/JF/SSBCI - VBID Package 1**

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?  | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Pest Control?   | No   |
|             |          | Notes:<br>Member will choose up to three (3) services per quarter (12 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card. | Yes  |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?   | Plan-approved Location                                       |
|             |          | Select enhanced benefit:   | Mandatory  |
|             |          | Select type of benefit for Plan-approved Location:   | No   |
|             |          | Is this benefit unlimited for number of trips for Plan-approved Location?  | 0  |
|             |          | Indicate number of trips for Plan-approved Location:   | Every year   |
|             |          | Select Plan-approved Location Trips periodicity:   | One-way  |
|             |          | Select Type of Transportation for Non-Medical Needs for Plan-approved Location:  | Van; Medical Transport                                       |
|             |          | Select Mode of Transportation for Non-Medical Need for Plan-approved Location:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
|             |          | Description:   | No   |
|             |          | Is this benefit unlimited for number of trips for Any Location?  | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response    |
|-------------|----------|---|-------------|
|             |          | Is there an enrollee Deductible?  | No          |
|             |          | Is there an enrollee Copayment?   | No          |
|             |          | Is authorization required?  | No          |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?   | No          |
|             |          | Notes:<br>Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card. |             |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?  | Yes         |
|             |          | Select type of benefit for Social Needs Benefit:  | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?   | Yes         |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00        |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No          |
|             |          | Is there an enrollee Coinsurance?   | No          |
|             |          | Is there an enrollee Deductible?  | No          |
|             |          | Is there an enrollee Copayment?   | No          |
|             |          | Is authorization required?  | No          |
|             |          | Is a referral required for Social Needs Benefit?  | No          |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.                           |
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Complementary Therapies:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                     | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                     | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                      | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Complementary Therapies?                                   | No   |
|             |          | Notes:  | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Services Supporting Self-Direction?                                   | No   |
|             |          | Notes:   | Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?        | Yes  |
|             |          | Select type of benefit for General Supports for Living:  | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |

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Contrato Número



**19b Additional Benefits for VBID/UF/SSBCCI - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category   | Question  | Response   |
|-------------|--|---|--|
|             |  | Is authorization required?  | No   |
|             |  | Is a referral required for General Supports for Living?<br>Notes:   | No   |
|             |  |   | Member may choose up to three (3) services per quarter (12 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. |
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:<br><br>Enter name of Service:<br>Select type of benefit for Other 1: | Other 1; Other 2; Other 3; Other 4   |
|             |  | Is there a service-specific Maximum Plan Benefit Coverage amount?   | No   |
|             |  | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |  | Is there an enrollee Coinsurance?   | No   |
|             |  | Is there an enrollee Deductible?  | No   |
|             |  | Is there an enrollee Copayment?   | No   |
|             |  | Is authorization required?  | No   |
|             |  | Is a referral required for Other 1 Services?  | No   |
|             |  | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.  |
|             |  | Enter name of Service:  | Pet care   |

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*[Handwritten Signature]*

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Select type of benefit for Other 2:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 2 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBID Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function  |
|             |          | Select type of benefit for Other 3:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 3 Services?                      | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to three (3) services per quarter (12 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.  |



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# Bid Reports 2024

## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
 H5577 - 046  
 VBID: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

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|   |   |
|---|---|
| Region:   | New York  |
| Lead Marketing Region:  | New York  |
| Org. Marketing Name:  | MCS Classicare  |
| Plan Name:  | MCS Classicare Platino Total (HMO D-SNP)                              |
| Plan Geographic Name:   | Puerto Rico   |
| Status:   | Version 3 - Renewal - Successfully exported to desk review (06/06/23) |
| Plan Type:  | HMO   |
| Enrollee Type:  | Part A and Part B   |
| Number of Tiers:  |   |
| Part D Plan Premium:  | N/A   |
| Continuation Area Available:  | No  |
| Visitor/Travel Benefit Available:   | US - No   |
| Formulary:  | Yes, 00024446   |
| Part D Benefit:   | Yes, Defined Standard   |
| Special Needs Plan:   | Yes   |
| Special Needs Plan Type:  | Dual-Eligible   |
| Dual-Eligible SNP:  | Medicare non-zero dollar cost sharing plan                            |
| Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? | Yes   |
| Standard Bid For Section B:   | No  |
| Standard Bid For Section C:   | No  |
| Standard Bid For Section D:   | No  |

| Part D Benefit Data  |  |
|--|--|
| Benefit  | Plan Data  |
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  |  |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |

|  |   |
|--|---|
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.  |
| Indicate which tiers have insulin drugs (Select all that apply):                           |   |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | \$35.00   |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | \$70.00   |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   |   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00  |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:            | \$35.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:            | \$35.00   |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply:            | \$35.00   |
| Vaccine Attestation:   | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold  |   |

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| General Data   |           |
|--|-----------|
| Benefit  | Plan Data |
| All drugs on formulary available at extended days supply   | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill?              | Yes       |
| Standard Retail Cost-sharing, 1 Month =  | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =   | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =   | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =   | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =   | 90 Days   |
| Long Term Care Pharmacy, 1 Month =   | 31 Days   |
| NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold |           |

*[Handwritten Signature]*



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

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Plan Service Area Report

MCS ADVANTAGE, INC.  
 HS577 - OAS  
 VBID: Yes - Part C  
 MA Uniformity Review: No  
 Special Supplemental Benefits for the Community Plan:  
 Part D Senior Savings Model: No

Region: New York  
 Local Marketing Region: New York  
 O.g. Marketing Name: MCS Advantage  
 Plan Name: MCS Advantage Puerto Rico (R020 D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Status: Version 3 - Renewal - Successfully created to del. review (06/06/23)  
 Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: 0.00  
 Part D Plan Premium: N/A  
 Continuation Period Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 00023435  
 Part D Benefit: Yes, ESRMS Standard  
 Special Needs Plan: No  
 Special Needs Plan Type: Dual Eligible SNP  
 Dual Eligible SNP: Under (SNP), has the state agreed to cover all Medicaid premiums and cost sharing for enrollees in your D-SNP?  
 Standard Bid for Section B: No  
 Standard Bid for Section C: No  
 Standard Bid for Section D: No

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| State       | County       | County Code | En (Ever-On) County? | Pending County? | Partial County? |
|-------------|--------------|-------------|----------------------|-----------------|-----------------|
| Puerto Rico | Aguadilla    | 40010       | No                   | No              | No              |
| Puerto Rico | Aguado       | 40020       | No                   | No              | No              |
| Puerto Rico | Aguadilla    | 40030       | No                   | No              | No              |
| Puerto Rico | Aguas Buenas | 40040       | No                   | No              | No              |
| Puerto Rico | Arroyo       | 40050       | No                   | No              | No              |
| Puerto Rico | Bayamon      | 40060       | No                   | No              | No              |
| Puerto Rico | Caguas       | 40070       | No                   | No              | No              |
| Puerto Rico | Cayey        | 40080       | No                   | No              | No              |
| Puerto Rico | Cidra        | 40090       | No                   | No              | No              |
| Puerto Rico | Comerio      | 40100       | No                   | No              | No              |
| Puerto Rico | Coroico      | 40110       | No                   | No              | No              |
| Puerto Rico | Culebra      | 40120       | No                   | No              | No              |
| Puerto Rico | Dorado       | 40130       | No                   | No              | No              |
| Puerto Rico | Fajardo      | 40140       | No                   | No              | No              |
| Puerto Rico | Florida      | 40150       | No                   | No              | No              |
| Puerto Rico | Guayama      | 40160       | No                   | No              | No              |
| Puerto Rico | Guaynabo     | 40170       | No                   | No              | No              |
| Puerto Rico | Hirsh        | 40180       | No                   | No              | No              |
| Puerto Rico | Honouliuli   | 40190       | No                   | No              | No              |
| Puerto Rico | Humacao      | 40200       | No                   | No              | No              |
| Puerto Rico | Isabela      | 40210       | No                   | No              | No              |
| Puerto Rico | Juncos       | 40220       | No                   | No              | No              |
| Puerto Rico | Lajas        | 40230       | No                   | No              | No              |
| Puerto Rico | Luis Ponce   | 40240       | No                   | No              | No              |
| Puerto Rico | Maguey       | 40250       | No                   | No              | No              |
| Puerto Rico | Manati       | 40260       | No                   | No              | No              |
| Puerto Rico | Maricao      | 40270       | No                   | No              | No              |
| Puerto Rico | Mayaguez     | 40280       | No                   | No              | No              |
| Puerto Rico | Medina       | 40290       | No                   | No              | No              |
| Puerto Rico | Morovis      | 40300       | No                   | No              | No              |
| Puerto Rico | Naguabo      | 40310       | No                   | No              | No              |
| Puerto Rico | Ponce        | 40320       | No                   | No              | No              |



# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.  
 H5577 - 046  
 VBID: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Platino Total (HMO D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Status: Version 3 - Renewal - Successfully exported to desk review (06/06/23)  
 Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$0.00  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 00024446  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Special Needs Plan Type: Dual-Eligible  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan

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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

| Plan Level Cost Shares and Limits  |                                      |
|--|--------------------------------------|
| Question   | Response                             |
| Is there an In-Network Plan Deductible?  | No                                   |
| 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 Lower, Intermediate or Mandatory Level? | Lower                                |
| 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  |
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |

| Reductions in Cost Sharing - General     |          |
|--|----------|
| Question                                 | Response |
| Do you offer Reductions in Cost Sharing? | No       |

| Combined Benefits - General  |  |
|--|--|
| Question   | Response   |
| Do you offer Combined Supplemental Benefits?   | Yes  |
| Select the number of Combined Supplemental Benefit packages you are offering?  | 2  |
| Combined Benefits Group 1 Name:  | Combined Eyewear and Hearing   |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 700.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |

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|  |   |
|--|---|
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No  |
| Combined Benefits Group 2 Name:  | Combined Transportation   |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBID/UF/SSBCI |
| What is your combined supplemental benefits mode of delivery?  | Other   |
| Other Description:   | Transportation provided by contracted vendors.  |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No  |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No  |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes   |
| Indicate number of shared visits:  | 24  |
| Select visit limit periodicity:  | Every year  |

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**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                   |       |                     |   |                           |     |                 |
|-------------------|-------|---------------------|---|---------------------------|-----|-----------------|
| 1 Contract Number | H5577 | 5 Organization Name | MCS ADVANTAGE, INC.<br>MCS Classicare Platino Total (HMO D-<br>SNP) | 9 Enrollee Type           | A/B | 13. Region Name |
| 2 Plan ID         | 046   | 6 Plan Name         |   | 10. MA Region:            | N/A |                 |
| 3 Segment ID      | 000   | 7 Plan Type:        | HMO   | 11. Act. Swap/Equiv Apply | N   |                 |
| 4 Contract Year:  | 2024  | 8 MA-PD             | Y   | 12. SNP:                  | Y   | 14. SNP Type:   |

**II. Other Information**

|  |          |  |        |
|--|----------|--|--------|
| <b>A. Part B Information</b>                 |          | <b>B. Rebate Allocation for Part B Premium</b>                       |        |
| 1 Maximum Part B premium buydown amt per CMS | \$164.90 | 1 PMPM Rebate Allocation for Part B premium (maximum value=\$164.90) | \$5.00 |
|  |          | 2 Part B Rebate Allocation rounded to one decimal (see instructions) | \$0.00 |

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# Appendix C-1

## Plan Benefit Package (PBP)

### H5577 – 054

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 054

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Region:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Segment ID:

Segment Geographic Name:

Status:

Plan Type:

Enrollee Type:

Part C Plan Premium:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

Part D Benefit:

Special Needs Plan:

Special Needs Plan Type:

Dual-Eligible SNP:

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Standard Bid For Section B:

Standard Bid For Section C:

Standard Bid For Section D:

New York

New York

MCS Classicare

MCS Classicare Platino Maximo (HMO D-SNP)

Puerto Rico

1

Region 1

Version 2 - Renewal - Successfully exported to desk review (06/06/23)

HMO

Part A and Part B

\$0.00

N/A

No

US - No

Yes, 00024446

Yes, Defined Standard

Yes

Dual-Eligible

Medicare non-zero dollar cost sharing plan

Yes

No

No

No

### Plan Level Data

Question

Response

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**Tiered Cost sharing for Part B Services**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**

**Benefit Description**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**

**Benefit Description**

|                 |                 |
|-----------------|-----------------|
| <b>Question</b> | <b>Response</b> |
|-----------------|-----------------|

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

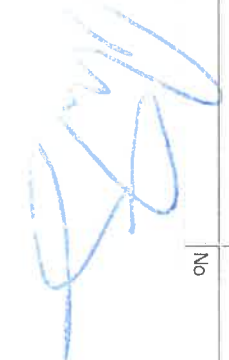
**Benefit Description**

|   |                 |
|---|-----------------|
| <b>Question</b>   | <b>Response</b> |
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No              |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No              |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

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

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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

| <b>2 Skilled Nursing Facility (SNF)</b> |                     |
|---|---------------------|
| Service Category Description            | Benefit Description |
| <b>Question</b>                         | <b>Response</b>     |

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

| Question                            | Response |
|-------------------------------------|----------|
| <b>4a Emergency Services</b>        |          |
| <b>Service Category Description</b> |          |
| <b>Benefit Description</b>          |          |

**Question**

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

**Response**

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

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

**4c Worldwide Emergency/Urgent Coverage**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**  
No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

No

Is a referral required for Partial Hospitalization?

No

**6 Home Health Services**

**Service Category Description**

**Benefit Description**

**Question**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Is authorization required?

Yes

Is a referral required for Home Health Services?

Yes

**7a Primary Care Physician Services**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**  
No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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**7b Chiropractic Services**  
**Service Category Description**  
**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**  
**Service Category Description**  
**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

**Benefit Description**

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

**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

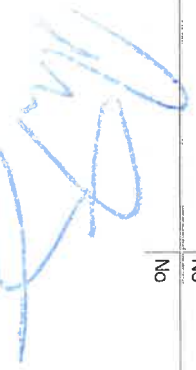
**Benefit Description**

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

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**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Psychiatric Services?                            | No       |

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

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

**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

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

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**7J Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Coinsurance?                             | No       |
| Is there an enrollee Deductible?                              | No       |
| Is there an enrollee Copayment?                               | No       |
| Is authorization required for Additional Telehealth Benefits? | No       |
| Is a referral required for Additional Telehealth Benefits?    | No       |

**7K Opioid Treatment Program Services**

**Service Category Description**

**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Lab Services:                | \$0.00   |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 12   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |

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**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Is authorization required?                          | No   |
| Is a referral required for Transportation Services? | No   |
| Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |

**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?               | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

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

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**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

| <b>Question</b>            | <b>Response</b>   |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>  | <b>Response</b>   |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

| Question  | Response             |
|---|----------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13b Over-the-Counter (OTC) Items**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

No

**13c Meal Benefit**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

**13d Other 1**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13e Other 2**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**13f Other 3**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13g Dual Eligible SNPs with Highly Integrated Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13i Non-Primarily Health Related Benefits for the Chronically III**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**14a Medicare-covered Zero Cost-Sharing Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Medicare-covered Zero Dollar Preventive Services Attestation

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

Is authorization required?

No

Is a referral required?

No

**14a Medicare-covered Zero Cost-Sharing Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**14b Annual Physical Exam**

**Service Category Description**

**Benefit Description**

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

**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Other Defined Supplemental Benefits as a benefit under Part C?                                | Yes  |
| Select enhanced benefit (Select all that apply):  | 14c1: Health Education; 14c2: Nutritional/Dietary Benefit; 14c4: Fitness Benefit*; 14c7: Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline)*; 14c17: Alternative Therapies*; 14c18: Therapeutic Massage |
| Select type of benefit for Health Education:  | Mandatory  |
| Select type of benefit for Nutritional/Dietary Benefit:   | Mandatory  |
| Is this benefit unlimited for Nutritional/Dietary Benefit?  | No, indicate number  |
| Indicate number of visits for Nutritional/Dietary Benefit:  | 6  |
| Indicate setting for Nutritional/Dietary Benefit:   | 0  |
| 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 Technologies (including Web/Phone-based technologies and Nursing Hotline): | Mandatory  |
| Select the type of Remote Access Technologies offered (Select all that apply):                                      | Web/Phone-based technologies; Nursing Hotline  |
| Select type of benefit for Alternative Therapies:   | Mandatory  |
| Is this benefit unlimited for Alternative Therapies?  | No, indicate number  |
| Indicate number of visits offered for Alternative Therapies:  | 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 periodically:   | Every Year   |

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14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

| Question  | Response  |
|---|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00  |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00  |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Other Defined Supplemental Benefits?   | No  |
| 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.  |
| 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. Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline. |
| 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.   |



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**14d Kidney Disease Education Services**

**Service Category Description**

**Benefit Description**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

|   |    |
|---|----|
| Is authorization required for Medicare-covered Digital Rectal Exams?        | No |
| Is authorization required for Medicare-covered EKG following Welcome Visit? | No |
| Is a referral required for any Services?                                    | No |

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

|  |   |
|--|---|
| Attestation:   | I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug. |
| Is there a Maximum Enrollee Out-of-Pocket Cost?  | No  |
| Is there an enrollee Coinsurance?  | No  |
| Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:                      | 0%  |
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:   | 0%  |
| Is there an enrollee Copayment?  | No  |
| Is there an enrollee Coinsurance for Insulin?  | No  |
| Is there an enrollee Copayment for Insulin?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is Authorization Required?   | Yes   |
| Does the plan offer step therapy?  | Yes   |
| Does the benefit step from (select all that apply):  | Part B to Part B?; Part D to Part B?  |
| Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit? | No  |

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

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

NO

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

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

Yes

Select enhanced benefits:

Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics; Other Oral/Maxillofacial Surgery, Other Services

Select type of benefit for Non-routine Services:

Mandatory

Is this benefit unlimited for Non-routine Services?

Yes

Select type of benefit for Diagnostic Services:

Mandatory

Is this benefit unlimited for Diagnostic Services?

No, indicate number

Indicate number of visits for Diagnostic Services:

1

Select the Diagnostic Services periodicity:

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

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 Oral/Maxillofacial Surgery, Other Services?

Yes

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

**Service Category Description**

| Question  | Response                         |
|---|----------------------------------|
| 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:  | 1000.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description**

**Benefit Description**

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

**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes   |
| Select type of benefit for Eyeglass lenses:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes   |
| Select type of benefit for Eyeglass frames:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass frames?                            | Yes   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes   |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period  |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes   |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 600.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Eyewear?                                       | No  |
| Notes:  | <p>Administración de Seguros de Salud</p> <p>Contrato Número 24 - 0004</p> <p>Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.</p> |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Select type of benefit for Routine Hearing Exams:                         | Mandatory           |
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

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

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Hearing Aids (all types):                                   | Mandatory  |
| Is this benefit unlimited for Hearing Aids (all types)?                                | No, indicate number  |
| Indicate quantity for Hearing Aids (all types):  | 2  |
| Select Hearing Aids (all types) periodicity:   | Every year   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                      | 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:   | 600.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every Year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

| Question | Response          |
|----------|-------------------|
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**Service Category Description**

**Benefit Description**

| Question | Response        |
|----------|-----------------|
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**19a Reduced Cost Sharing for VBID/UF/SSBCI**

| Question  | Response  |
|---|---|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?  | No  |
| Do you offer Special Supplemental Benefits for the Chronically Ill?   | No  |
| Are you offering a VBID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)                            | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?   | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (choose one or more):  | 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?  | 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  |
| Expected Number of Beneficiaries to be Engaged Annually:  | 1139  |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                          | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:  | Analytics tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening. Other, Describe  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:  | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.  |
| Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

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**19b Additional Benefits for VBID/UF/SSBCI**

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

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                              | Question   | Response  |
|-------------|---------------------------------------|--|---|
| 19b         | Additional Benefits for VBID/UF/SSBCI | Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?                                | VBID  |
|             |                                       | Targeting Methodology - Please choose one or both:   | Socioeconomic Status  |
|             |                                       | Select LIS reduction level:  | Dual-Eligible Status (for territories)  |
|             |                                       | Expected Number of Enrollees to be Targeted:   | 1139  |
|             |                                       | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 1139  |
|             |                                       | Does the enrollee need to have all diseases selected to qualify?   | No  |
|             |                                       | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No  |
|             |                                       | Is there a prerequisite for any additional benefits for this package?                                    | No  |
|             |                                       | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 13110: General Supports for Living; 1311: Food and Produce; 1313: Pest Control; 1314: Transportation for Non-Medical Needs; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-O1: Other 1 Non-Primarily Health Related Benefit; 131-O2: Other 2 Non-Primarily Health Related Benefit; 131-O3: Other 3 Non-Primarily Health Related Benefit; 131-O4: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit |
|             |                                       | Are any benefits exempt from the plan-level deductible?  | No  |
|             |                                       | Is there a package level maximum coverage amount?  | No  |

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**19b Additional Benefits for VBIID/UF/SSBCI - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category   | Question   | Response  |
|-------------|--|--|---|
| 19b - 13i   | Additional Benefits for VBIID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living |
|             |  | Does the plan provide Food and Produce as a supplemental benefit under Part C?                           | Yes   |
|             |  | Select type of benefit for Food and Produce:   | Mandatory   |
|             |  | Is there a service-specific Maximum Plan Benefit Coverage amount?  | Yes   |
|             |  | Indicate Maximum Plan Benefit Coverage amount:   | 210.00  |
|             |  | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |
|             |  | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |  | Is there an enrollee Coinsurance?  | No  |
|             |  | Is there an enrollee Deductible?   | No  |
|             |  | Is there an enrollee Copayment?  | No  |
|             |  | Is authorization required?   | No  |
|             |  | Is a referral required for Food and Produce?   | No  |
|             |  | Notes:   | Maximum Plan Benefit Coverage amount on VBIID Benefits Card carries forward to the next period if it is unused.   |
|             |  | Does the plan provide Pest Control as a supplemental benefit under Part C?                               | Yes   |
|             |  | Select type of benefit for Pest Control:   | Mandatory   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?   | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Pest Control?  | No   |
|             |          | Notes:<br>Member will choose up to two (2) services per quarter (8 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card. |  |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?  | Yes  |
|             |          | 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?   | No   |
|             |          | Indicate number of trips for Plan-approved Location:  | 0  |
|             |          | Select Plan-approved Location Trips periodicity:  | Every year   |
|             |          | 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:  | Van; Medical Transport                                       |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps. |
|             |          | Is this benefit unlimited for number of trips for Any Location?   | No   |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?              | No  |
|             |          | Notes:   | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Yes   |
|             |          | Select type of benefit for Social Needs Benefit:                                   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                  | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                                     | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                  | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Social Needs Benefit?                                   | No  |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.                           |
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Complementary Therapies:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                     | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                     | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                      | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Complementary Therapies?                                   | No   |
|             |          | Notes:  | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). |

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

Disease States:

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required for Services Supporting Self-Direction?                                | No   |
|             |          | Notes:   | Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?        | Yes  |
|             |          | Select type of benefit for General Supports for Living:  | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
|             |   | Is a referral required for General Supports for Living?<br><br>Notes:  | No<br><br>Member may choose up to two (2) services per quarter (8 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. |
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primary Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primary Health Related Benefits for the Chronically Ill includes:<br><br>Enter name of Service:<br><br>Select type of benefit for Other 1:<br><br>Is there a service-specific Maximum Plan Benefit Coverage amount?<br><br>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?<br><br>Is there an enrollee Coinsurance?<br><br>Is there an enrollee Deductible?<br><br>Is there an enrollee Copayment?<br><br>Is authorization required?<br><br>Is a referral required for Other 1 Services?<br><br>Notes: | Other 1; Other 2; Other 3; Other 4<br><br>Home cleaning<br><br>Mandatory<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>Member may choose up to two (2) services per quarter (8 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.<br><br>Pet care<br><br>Mandatory   |

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**19b Additional Benefits for VBI/UF/SSBCI - VBI/UF Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response  |
|-------------|----------|---|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is there a referral required for Other 2 Services?                | No  |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBI/UF Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function   |
|             |          | Select type of benefit for Other 3:                               | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 3 Services?                      | No  |

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**19b Additional Benefits for VBID/UF/SSBCT - VBID Package 1**

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question  | Response  |
|-------------|----------|---|---|
|             |          | Notes:  | Items/services that support memory, fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling   |
|             |          | Select type of benefit for Other 4:                               | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 4 Services?                      | No  |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.  |

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 054

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 2  
Segment Geographic Name: Region 2  
Status: Version 2 - Renewal - Successfully exported to desk review (06/06/23)  
Plan Type: HMO  
Enrollee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Special Needs Plan Type: Dual-Eligible  
Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

### Plan Level Data

| Question | Response   |
|----------|--|
|          |  |

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**Tiered Cost sharing for Part B Services**

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

**1a Inpatient Hospital-Acute  
Service Category Description**

**Benefit Description**

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

**1a Inpatient Hospital-Acute**

**Service Category Description**

**Benefit Description**

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

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|   |                 |
|---|-----------------|
| <b>Question</b>   | <b>Response</b> |
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No              |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No              |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

\$0.00

Indicate Maximum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:

\$0.00

Is authorization required?

Yes

Is a referral required for Cardiac and Pulmonary Rehabilitation Services?

No

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

Is there an enrollee Coinsurance?

No

Is there an enrollee Copayment?

No

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**4b Urgently Needed Services**  
**Service Category Description**  
**Benefit Description**

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

**4c Worldwide Emergency/Urgent Coverage**  
**Service Category Description**  
**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**  
**Service Category Description**  
**Benefit Description**

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

**6 Home Health Services**  
**Service Category Description**  
**Benefit Description**

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

**7a Primary Care Physician Services**  
**Service Category Description**  
**Benefit Description**

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

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**7b Chiropractic Services**  
**Service Category Description**  
**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**  
**Service Category Description**  
**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

**Benefit Description**

| <b>Question</b>  | <b>Response</b>                                  |
|--|--|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?             | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Is authorization required?   | Yes  |
| Is a referral required for Mental Health Specialty Services - Non-Physician? | No   |
| Notes:   | Preauthorization required through MCS Solutions. |
| Notes:   | Preauthorization required through MCS Solutions. |

**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| <b>Question</b> | <b>Response</b> |
|-----------------|-----------------|
|                 |                 |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

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**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Psychiatric Services?                            | No       |

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

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

**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Coinsurance?                             | No       |
| Is there an enrollee Deductible?                              | No       |
| Is there an enrollee Copayment?                               | No       |
| Is authorization required for Additional Telehealth Benefits? | No       |
| Is a referral required for Additional Telehealth Benefits?    | No       |

**7k Opioid Treatment Program Services**

**Service Category Description**

**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Lab Services:                | \$0.00   |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 12   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every Year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |

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**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Is authorization required?                          | No   |
| Is a referral required for Transportation Services? | No   |
| Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |

**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?               | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)? | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

**11b Prosthetics/Medical Supplies**


**Service Category Description**

**Benefit Description**

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

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**11b Prosthetics / Medical Supplies**

**Service Category Description**

**Benefit Description**

| Question                   | Response  |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

**11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts**  
**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |



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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

**Response**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Response**

|   |                      |
|---|----------------------|
| <b>Question</b>   | <b>Response</b>      |
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every Year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13b Over-the-Counter (OTC) Items**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

No

**13c Meal Benefit**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

**13d Other 1**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13e Other 2**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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13f Other 3

|                                     |                 |
|-------------------------------------|-----------------|
| <b>Service Category Description</b> |                 |
| <b>Benefit Description</b>          |                 |
| <b>Question</b>                     | <b>Response</b> |

13g Dual Eligible SNPs with Highly Integrated Services

|                                     |                 |
|-------------------------------------|-----------------|
| <b>Service Category Description</b> |                 |
| <b>Benefit Description</b>          |                 |
| <b>Question</b>                     | <b>Response</b> |

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

|                                     |                 |
|-------------------------------------|-----------------|
| <b>Service Category Description</b> |                 |
| <b>Benefit Description</b>          |                 |
| <b>Question</b>                     | <b>Response</b> |

14a Medicare-covered Zero Cost-Sharing Preventive Services

|  |   |
|--|---|
| <b>Service Category Description</b>                          |   |
| <b>Benefit Description</b>                                   |   |
| <b>Question</b>  | <b>Response</b>   |
| 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?

|  |                 |
|--|-----------------|
| <b>Service Category Description</b>                        |                 |
| <b>Benefit Description</b>                                 |                 |
| <b>Question</b>  | <b>Response</b> |
| 14a Medicare-covered Zero Cost-Sharing Preventive Services |                 |

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**14b Annual Physical Exam**

**Service Category Description**

**Benefit Description**

**Question**

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

**Response**

No

**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

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

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

6

Indicate setting for Nutritional/Dietary Benefit:

Mandatory

Select type of benefit for Fitness Benefit:

Physical Fitness

Indicate type of Fitness Benefit offered (Select all that apply):

Mandatory

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

Web/Phone-based technologies; Nursing Hotline

Select the type of Remote Access Technologies offered (Select all that apply):

Mandatory

Select type of benefit for Alternative Therapies:

No, indicate number

Is this benefit unlimited for Alternative Therapies?

6

Indicate number of visits offered for Alternative Therapies:

Mandatory

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 periodically:

Every Year

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**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00  |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00  |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Alternative Therapies:  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00  |
| Is a referral required for Other Defined Supplemental Benefits?   | No  |
| 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.  |
| 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. Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline. |
| 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.   |

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**14d Kidney Disease Education Services**

**Service Category Description**

**Benefit Description**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Is authorization required for Medicare-covered Digital Rectal Exams?

No

Is authorization required for Medicare-covered EKG following Welcome Visit?

No

Is a referral required for any Services?

No

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Attestation:

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

Is there a Maximum Enrollee Out-of-Pocket Cost?

No

Is there an enrollee Coinsurance?

No

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:

0%

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:

0%

Is there an enrollee Copayment?

No

Is there an enrollee Coinsurance for Insulin?

No

Is there an enrollee Copayment for Insulin?

No

Is there an enrollee Deductible?

No

Is Authorization Required?

Yes

Does the plan offer step therapy?

Yes

Does the benefit step from (select all that apply):

Part B to Part B?; Part D to Part B?

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

No

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

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?

No

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

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

Yes

Select enhanced benefits:

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

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 Oral/Maxillofacial Surgery, Other Services?

Yes

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

**Service Category Description**

**Benefit Description**

| Question  | Response                         |
|---|----------------------------------|
| Is 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:  | 1000.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every Year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description**

**Benefit Description**

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

**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes   |
| Select type of benefit for Eyeglass lenses:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes   |
| Select type of benefit for Eyeglass frames:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass frames?                            | Yes   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes   |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period  |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes   |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 600.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every Year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Eyewear?                                       | No  |
| Notes:  | Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |

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**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Select type of benefit for Routine Hearing Exams:                         | Mandatory           |
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

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

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Hearing Aids (all types):                                   | Mandatory  |
| Is this benefit unlimited for Hearing Aids (all types)?                                | No, indicate number  |
| Indicate quantity for Hearing Aids (all types):  | 2  |
| Select Hearing Aids (all types) periodicity:   | Every year   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                      | 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:   | 600.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

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

**Service Category Description**

**Benefit Description**

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**19a Reduced Cost Sharing for VBID/UF/SSBCI**

| Question  | Response  |
|---|---|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?  | No  |
| Do you offer Special Supplemental Benefits for the Chronically Ill?   | No  |
| Are you offering a VBID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)                            | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?   | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (Choose one or more):  | 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?  | 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  |
| Expected Number of Beneficiaries to be Engaged Annually:  | 3026  |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                          | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:  | Analytics Tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening. Other, Describe  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:  | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.  |
| Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

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*[Handwritten signature]* *[Handwritten initials]*

**19b Additional Benefits for VBIID/UF/SSBCI**

| Question  | Response |
|---|----------|
| Does your VBIID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits? | No       |
| How many packages do your Additional Benefits contain? (1-15)                             | 1        |

**19b Additional Benefits for VBIID/UF/SSBCI - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                               | Question   | Response  |
|-------------|--|--|---|
| 19b         | Additional Benefits for VBIID/UF/SSBCI | Is this package applicable to VBIID or MA Uniformity Flexibility or SSBCI?                               | VBIID   |
|             |  | Targeting Methodology - Please choose one or both:   | Socioeconomic Status  |
|             |  | Select LIS reduction level:  | Dual-Eligible Status (for territories)  |
|             |  | Expected Number of Enrollees to be Targeted:   | 3026  |
|             |  | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 3026  |
|             |  | Does the enrollee need to have all diseases selected to qualify?   | No  |
|             |  | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No  |
|             |  | Is there a prerequisite for any additional benefits for this package?                                    | No  |
|             |  | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 13110: General Supports for Living; 1311: Food and Produce; 1313: Pest Control; 1314: Transportation for Non-Medical Needs; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-01: Other 1 Non-Primarily Health Related Benefit; 131-02: Other 2 Non-Primarily Health Related Benefit; 131-03: Other 3 Non-Primarily Health Related Benefit; 131-04: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit |
|             |  | Are any benefits exempt from the plan-level deductible?  | No  |
|             |  | Is there a package level maximum coverage amount?  | No  |

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**19b Additional Benefits for VBIID/UF/SSBICI - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
| 19b - 131   | Additional Benefits for VBIID/UF/SSBICI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:<br><br>Does the plan provide Food and Produce as a supplemental benefit under Part C?<br><br>Select type of benefit for Food and Produce:<br><br>Is there a service-specific Maximum Plan Benefit Coverage amount?<br><br>Indicate Maximum Plan Benefit Coverage amount:<br><br>Select Maximum Plan Benefit Coverage periodicity:<br><br>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?<br><br>Is there an enrollee Coinsurance?<br><br>Is there an enrollee Deductible?<br><br>Is there an enrollee Copayment?<br><br>Is authorization required?<br><br>Is a referral required for Food and Produce?<br><br>Notes:<br><br>Does the plan provide Pest Control as a supplemental benefit under Part C?<br><br>Select type of benefit for Pest Control: | A VBIID Benefits Card can be used towards Food & Produce, indoor air quality equipment and services, social needs, complementary therapies, services supporting self-direction, some General Supports for Living, pet care supplies and memory fitness items. A separate benefit is offered where the member may choose 2 visits per quarter (8 visits annually) for home assistance services filed under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The Transportation for Non-Medical Needs is combined with the base package transportation for health-related needs.<br><br>Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living<br><br>Yes<br><br>Mandatory<br><br>Yes<br><br>180.00<br>Every month<br>No<br>No<br>No<br>No<br>No<br>No<br>No<br>Yes<br><br>Mandatory |
|             |   |  | <p>ADMINISTRACION DE<br/>SEGUROS DE SALUD</p> <p>№ 2 4 - 0 0 0 4</p> <p>Contrato Número<br/>2412</p>  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                  | No  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Pest Control?   | No  |
|             |          | Notes:   | Member will choose up to two (2) services per quarter (8 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? | Yes   |
|             |          | 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?                          | No  |
|             |          | Indicate number of trips for Plan-approved Location:   | 0   |
|             |          | Select Plan-approved Location Trips periodicity:   | Every year  |
|             |          | 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:                     | Van; Medical Transport  |
|             |          | Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.  |
|             |          | Is this benefit unlimited for number of trips for Any Location?                                    | No  |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?                        | No   |
|             |          | Notes:<br>Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card.<br>Yes |
|             |          | Select type of benefit for Social Needs Benefit:   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                            | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                             | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Social Needs Benefit?   | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.                           |
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Complementary Therapies:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                     | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                     | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                      | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Complementary Therapies?                                   | No   |
|             |          | Notes:  | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Services Supporting Self-Direction?                                   | No   |
|             |          | Notes:   | Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?        | Yes  |
|             |          | Select type of benefit for General Supports for Living:  | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
|             |   | Is a referral required for General Supports for Living?  | No  |
|             |   | Notes:   | Member may choose up to two (2) services per quarter (8 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. |
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Other 1; Other 2; Other 3; Other 4  |
|             |   | Enter name of Service:   | Home cleaning   |
|             |   | Select type of benefit for Other 1:  | Mandatory   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | No  |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Other 1 Services?   | No  |
|             |   | Notes:   | Member may choose up to two (2) services per quarter (8 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.  |
|             |   | Enter name of Service:   | Pet care  |
|             |   | Select type of benefit for Other 2:  | Mandatory   |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question  | Response  |
|-------------|----------|---|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 2 Services?                      | No  |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBID Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function   |
|             |          | Select type of benefit for Other 3:                               | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 3 Services?                      | No  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.   |

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 054

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically Ill: No

Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 3  
Segment Geographic Name: Region 3  
Status: Version 2 - Renewal - Successfully exported to desk review (06/06/23)  
Plan Type: HMO  
Enrollee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Forfeiture: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Dual-Eligible: Dual-Eligible  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Medicare non-zero dollar cost sharing plan  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

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| Question        | Response |
|-----------------|----------|
| Plan Level Data |          |

**Tiered Cost sharing for Part B Services**

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

**1a Inpatient Hospital-Acute  
Service Category Description**

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

**1a Inpatient Hospital-Acute  
Service Category Description**

|                            |                 |
|----------------------------|-----------------|
| <b>Benefit Description</b> | <b>Response</b> |
| <b>Question</b>            |                 |

**1b Inpatient Hospital-Psychiatric  
Service Category Description**

|   |                 |
|---|-----------------|
| <b>Benefit Description</b>  | <b>Response</b> |
| <b>Question</b>   |                 |
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No              |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No              |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

| Question   | Response |
|--|----------|
| <b>3 Cardiac and Pulmonary Rehabilitation Services</b> |          |
| <b>Service Category Description</b>                    |          |
| <b>Benefit Description</b>                             |          |

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

|                 |                 |
|-----------------|-----------------|
| <b>Question</b> | <b>Response</b> |
|                 |                 |

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

|  |                 |
|--|-----------------|
| <b>Question</b>  | <b>Response</b> |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | No              |
| Is there an enrollee Coinsurance?                                | No              |
| Is there an enrollee Copayment?                                  | No              |

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

|                 |                 |
|-----------------|-----------------|
| <b>Question</b> | <b>Response</b> |
|                 |                 |

**4b Urgently Needed Services**

**Service Category Description**

**Benefit Description**

|                 |                 |
|-----------------|-----------------|
| <b>Question</b> | <b>Response</b> |
|                 |                 |

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**4b Urgently Needed Services**  
**Service Category Description**

| Benefit Description  | Response |
|--|----------|
| <b>Question</b>  |          |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | No       |
| Is there an enrollee Coinsurance?                                | No       |
| Is there an enrollee Copayment?                                  | No       |

**4c Worldwide Emergency/Urgent Coverage**  
**Service Category Description**

| Benefit Description   | Response   |
|---|--|
| <b>Question</b>   |  |
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**

**Service Category Description**

**Benefit Description**

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

**6 Home Health Services**

**Service Category Description**

**Benefit Description**

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

**7a Primary Care Physician Services**

**Service Category Description**

**Benefit Description**

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

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**7b Chiropractic Services**

**Service Category Description**  
**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every Year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**

**Service Category Description**  
**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

**Benefit Description**

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

**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | No       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Podiatrist Services?                                 | Yes      |

**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

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

**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

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**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:      | \$0.00   |
| Is authorization required?  | No       |
| Is a referral required for Psychiatric Services?                            | No       |

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Coinsurance?                             | No       |
| Is there an enrollee Deductible?                              | No       |
| Is there an enrollee Copayment?                               | No       |
| Is authorization required for Additional Telehealth Benefits? | No       |
| Is a referral required for Additional Telehealth Benefits?    | No       |

**7k Opioid Treatment Program Services**

**Service Category Description**

**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No       |
| Is there an enrollee Coinsurance?   | No       |
| Is there an enrollee Deductible?  | No       |
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests: | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Lab Services:                | \$0.00   |

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

**9b Ambulatory Surgical Center (ASC) Services**

**Service Category Description**

**Benefit Description**

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

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**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

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**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Does the plan provide Transportation Services as a supplemental benefit under Part C?    | Yes  |
| Select enhanced benefit:   | Plan Approved Health-related Location                        |
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 12   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe                           |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps. |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |



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**10b Transportation Services**

**Service Category Description**

**Benefit Description**

**Question**

Is authorization required?

**Response**  
No

Is a referral required for Transportation Services?

No

Notes:

Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRMs, and 1314 - Transportation for Non-Medical Needs.

**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**  
No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

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

Yes

Is authorization required?

Yes

Notes:

Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**  
No

Is there an enrollee Coinsurance?

No

Is there an enrollee Deductible?

No

Is there an enrollee Copayment?

No

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

\$0.00

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

\$0.00

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**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

| Question                   | Response  |
|----------------------------|---|
| Is authorization required? | Yes   |
| Notes:                     | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                       | No  |
| Is there an enrollee Coinsurance?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is there an enrollee Copayment?  | No  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:                     | \$0.00  |
| Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

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**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

| Question  | Response             |
|---|----------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                  |
| Select enhanced benefit:  | Number of Treatments |
| Select type of benefit for Number of Treatments:                          | Mandatory            |
| Is this benefit unlimited for Number of Treatments?                       | No                   |
| Indicate limit for Number of Treatments:                                  | 6                    |
| Indicate Number of Treatments periodicity:                                | Every year           |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                   |
| 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                   |

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**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13b Over-the-Counter (OTC) Items**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

No

**13c Meal Benefit**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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

No

**13d Other 1**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13e Other 2**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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13f Other 3

Service Category Description

Benefit Description

Question

Response

13g Dual Eligible SNPs with Highly Integrated Services

Service Category Description

Benefit Description

Question

Response

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

Service Category Description

Benefit Description

Question

Response

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question

Response

Medicare-covered Zero Dollar Preventive Services Attestation

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

Is authorization required?

No

Is a referral required?

No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question

Response

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14b Annual Physical Exam

Service Category Description

Benefit Description

Question

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

Response

No

14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question

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

Response

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

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

6

Indicate setting for Nutritional/Dietary Benefit:

0

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 Technologies (Including Web/Phone-based technologies and Nursing Hotline):

Mandatory

Select the type of Remote Access Technologies offered (Select all that apply):

Web/Phone-based technologies; Nursing Hotline

Select type of benefit for Alternative Therapies:

Mandatory

Is this benefit unlimited for Alternative Therapies?

No, indicate number

Indicate number of visits offered for Alternative Therapies:

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

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**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

| Question  |  | Response  |
|---|--|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits? |  | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?  |  | No  |
| Is there an enrollee Coinsurance?   |  | No  |
| Is there an enrollee Deductible?  |  | No  |
| Is there an enrollee Copayment?   |  | No  |
| Indicate Minimum Copayment amount for Health Education:   |  | \$0.00  |
| Indicate Maximum Copayment amount for Health Education:   |  | \$0.00  |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  |  | \$0.00  |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  |  | \$0.00  |
| Indicate Minimum Copayment amount for Fitness Benefit:  |  | \$0.00  |
| Indicate Maximum Copayment amount for Fitness Benefit:  |  | \$0.00  |
| Indicate Minimum Copayment amount for Alternative Therapies:  |  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  |  | \$0.00  |
| Is a referral required for Other Defined Supplemental Benefits?   |  | No  |
| 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.  |
| 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. Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline. |
| 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.   |

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**14d Kidney Disease Education Services**

**Service Category Description**

**Benefit Description**

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

**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is authorization required for Medicare-covered Digital Rectal Exams?        | No       |
| Is authorization required for Medicare-covered EKG following Welcome Visit? | No       |
| Is a referral required for any Services?                                    | No       |

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

| Question   | Response  |
|--|---|
| Attestation:   | I attest that the MA enrollee cost sharing for a Part B rebatable drug will not exceed the coinsurance amount of the original Medicare adjusted beneficiary coinsurance for that Part B rebatable drug. In applying this effective coinsurance percentage, MA plans may continue to base enrollee cost sharing off of the total MA plan financial liability for that Part B drug. |
| Is there a Maximum Enrollee Out-of-Pocket Cost?  | No  |
| Is there an enrollee Coinsurance?  | No  |
| Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:                      | 0%  |
| Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:   | 0%  |
| Is there an enrollee Copayment?  | No  |
| Is there an enrollee Coinsurance for Insulin?  | No  |
| Is there an enrollee Copayment for Insulin?  | No  |
| Is there an enrollee Deductible?   | No  |
| Is Authorization Required?   | Yes   |
| Does the plan offer step therapy?  | Yes   |
| Does the benefit step from (select all that apply):  | Part B to Part B?, Part D to Part B?  |
| Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit? | No  |

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>   | <b>Response</b> |
|---|-----------------|
| Does the plan provide Preventive Dental Items as a supplemental benefit under Part C? | No              |

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>   | <b>Response</b>   |
|---|---|
| Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?        | Yes   |
| Select enhanced benefits:   | Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics; Other Oral/Maxillofacial Surgery, Other Services |
| Select type of benefit for Non-routine Services:  | Mandatory   |
| Is this benefit unlimited for Non-routine Services?   | Yes   |
| Select type of benefit for Diagnostic Services:   | Mandatory   |
| Is this benefit unlimited for Diagnostic Services?  | No, indicate number   |
| Indicate number of visits for Diagnostic Services:  | 1   |
| Select the Diagnostic Services periodicity:   | 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   |
| 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 Oral/Maxillofacial Surgery, Other Services? | Yes   |

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

**Service Category Description**

**Benefit Description**

| Question  | Response                         |
|---|----------------------------------|
| Is 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:  | 1000.00                          |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every year                       |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No                               |
| Is there an enrollee Coinsurance?   | No                               |
| Is there an enrollee Deductible?  | No                               |
| Is there an enrollee Copayment?   | No                               |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00                           |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00                           |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00                           |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00                           |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00                           |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00                           |
| Is authorization required?  | Yes                              |
| Is a referral required for Comprehensive Dental Services?   | No                               |

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**17a Eye Exams**

**Service Category Description**  
**Benefit Description**

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

**17b Eyewear**

**Service Category Description**  
**Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| 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  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is this benefit unlimited for Eyeglasses (lenses and frames)?             | Yes   |
| Select type of benefit for Eyeglass lenses:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass lenses?                            | Yes   |
| Select type of benefit for Eyeglass frames:                               | Mandatory   |
| Is this benefit unlimited for Eyeglass frames?                            | Yes   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes   |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period  |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes   |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 600.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Eyewear?                                       | No  |
| Notes:  | Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. |

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**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |

**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Select type of benefit for Routine Hearing Exams:                         | Mandatory           |
| Is this benefit unlimited for Routine Hearing Exams?                      | No, indicate number |
| Indicate number for Routine Hearing Exams:                                | 1                   |
| Select Routine Hearing Exams periodicity:                                 | Every Year          |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:            | Mandatory           |
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every Year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

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

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Hearing Aids (all types):                                   | Mandatory  |
| Is this benefit unlimited for Hearing Aids (all types)?                                | No, indicate number  |
| Indicate quantity for Hearing Aids (all types):  | 2  |
| Select Hearing Aids (all types) periodicity:   | Every year   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                      | 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:   | 600.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          | EMR      |

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

**Service Category Description**

**Benefit Description**

| Question | Response   |
|----------|--|
|          |  |

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**19a Reduced Cost Sharing for VBD/UF/SSBCT**

| Question   | Response   |
|--|--|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?   | No   |
| Do you offer Special Supplemental Benefits for the Chronically Ill?  | No   |
| Are you offering a VBD Hospice Benefit?  | No   |
| Are you offering Part C benefits under the VBD Model? (VBD Part D Rewards and Incentives programs should be entered in Section Rx)                             | Yes  |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?  | Value-Based Design Flexibilities by Condition or Socioeconomic Status  |
| WHP Program Type (choose one or more):   | 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?   | 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   |
| Expected Number of Beneficiaries to be Engaged Annually:   | 5168   |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                         | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe   |
| Identify actions within your VBD HEP. (Select all that apply):   | <p>Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts</p> |
| Description:   | Analytics tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening. Other, Describe   |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBD targeted enrollee populations. (Select all that apply): | Other, Describe  |
| Description:   | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.   |
| Does your VBD/MA Uniformity Flexibility/SSBCT benefit offer Part C reductions in cost?   | Yes  |

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**19b Additional Benefits for VBID/UF/SSBCI**

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

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category                              | Question   | Response   |
|-------------|---------------------------------------|--|--|
| 19b         | Additional Benefits for VBID/UF/SSBCI | Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?                                | VBID   |
|             |                                       | Targeting Methodology - Please choose one or both:   | Socioeconomic Status   |
|             |                                       | Select LIS reduction level:  | Dual-Eligible Status (for territories)   |
|             |                                       | Expected Number of Enrollees to be Targeted:   | 5168   |
|             |                                       | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 5168   |
|             |                                       | Does the enrollee need to have all diseases selected to qualify?   | No   |
|             |                                       | Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes. | No   |
|             |                                       | Is there a prerequisite for any additional benefits for this package?                                    | No   |
|             |                                       | Select all the Non-Medicare-covered additional benefits offered in this package:                         | <p align="center"><i>EMR</i></p> <p>1310: General Supports for Living; 1311: Food and Produce; 1313: Pest Control; 1314: Transportation for Non-Medical Needs; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-01: Other 1 Non-Primarily Health Related Benefit; 131-02: Other 2 Non-Primarily Health Related Benefit; 131-03: Other 3 Non-Primarily Health Related Benefit; 131-04: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit</p> |
|             |                                       | Are any benefits exempt from the plan-level deductible?  | No   |
|             |                                       | Is there a package level maximum coverage amount?  | No   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | A VBID Card using the base package OTC monthly coverage amount can be used towards Food & Produce, indoor air quality equipment and services, social needs, complementary therapies, services supporting self-direction, some General Supports for Living, pet care supplies and memory fitness items. A separate benefit is offered where the member may choose 2 visits per quarter (8 visits annually) for home assistance services filed under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The Transportation for Non-Medical Needs is combined with the base package transportation for health-related needs. |
|             |   | Does the plan provide Food and Produce as a supplemental benefit under Part C?                           | Yes   |
|             |   | Select type of benefit for Food and Produce:   | Mandatory   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | Yes   |
|             |   | Indicate Maximum Plan Benefit Coverage amount:   | 160.00  |
|             |   | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Food and Produce?   | No  |
|             |   | Notes:   | Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.  |
|             |   | Does the plan provide Pest Control as a supplemental benefit under Part C?                               | Yes   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Select type of benefit for Pest Control:   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                  | No  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Pest Control?   | No  |
|             |          | Notes:   | Member will choose up to two (2) services per quarter (8 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control Items are covered through the SSBCI Card. |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? | Yes   |
|             |          | 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?                          | No  |
|             |          | Indicate number of trips for Plan-approved Location:   | 0   |
|             |          | Select Plan-approved Location Trips periodicity:   | Every Year  |
|             |          | 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:                     | Van; Medical Transport  |
|             |          | Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.  |
|             |          | Is this benefit unlimited for number of trips for Any Location?                                    | No  |

Contrato Número  
# 2 4 - 0 0 0 4  
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**19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Indicate number of trips for Any Location:  | 0  |
|             |          | Select Any Location Trips periodicity:  | Every Year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?              | No  |
|             |          | Notes:   | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the SSBCI Card. |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Yes   |
|             |          | Select type of benefit for Social Needs Benefit:                                   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                  | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                                     | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                  | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Social Needs Benefit?                                   | No  |

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SEGUROS DE SALUD

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Contrato Número

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Notes:<br>Does the plan provide Complementary Therapies as a supplemental benefit under Part C?<br>Select type of benefit for Complementary Therapies:<br>Is there a service-specific Maximum Plan Benefit Coverage amount?<br>Indicate Maximum Plan Benefit Coverage amount:<br>Select Maximum Plan Benefit Coverage periodicity:<br>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | Social Needs are covered through the SSBCI Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.<br>Yes<br>Mandatory<br>Yes<br>0.00<br>Every month |
|             |          | Is there an enrollee Coinsurance?<br>Is there an enrollee Deductible?<br>Is there an enrollee Copayment?<br>Is a referral required for Complementary Therapies?  | No<br>No<br>No<br>No<br>Contrato Número  |
|             |          | Notes:<br>Complementary therapies are covered through the SSBCI Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, and probiotic or probiotic products are also commonly used (NCCIM, 2016a). | No   |

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Contrato Número



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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Services Supporting Self-Direction?                                   | No   |
|             |          | Notes:   | Services supporting self-direction are covered through the SSBCI Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C?        | Yes  |
|             |          | Select type of benefit for General Supports for Living:  | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |

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**19b Additional Benefits for VBIID/UF/SSBCT - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category   | Question   | Response  |
|-------------|--|--|---|
|             |  | Is a referral required for General Supports for Living?  | No  |
|             |  | Notes:   | Member may choose up to two (2) services per quarter (8 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the SSBCT Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil. |
| 19b - 131   | Additional Benefits for VBIID/UF/SSBCT - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Other 1; Other 2; Other 3; Other 4  |
|             |  | Enter name of Service:   | Home cleaning   |
|             |  | Select type of benefit for Other 1:  | Mandatory   |
|             |  | Is there a service-specific Maximum Plan Benefit Coverage amount?  | No  |
|             |  | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |  | Is there an enrollee Coinsurance?  | No  |
|             |  | Is there an enrollee Deductible?   | No  |
|             |  | Is there an enrollee Copayment?  | No  |
|             |  | Is authorization required?   | No  |
|             |  | Is a referral required for Other 1 Services?   | No  |
|             |  | Notes:   | Member may choose up to two (2) services per quarter (8 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.  |
|             |  | Enter name of Service:   | Pet care  |
|             |  | Select type of benefit for Other 2:  | Mandatory   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response  |
|-------------|----------|---|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 2 Services?                      | No  |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the SSBCI card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function   |
|             |          | Select type of benefit for Other 3:                               | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 3 Services?                      | No  |

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Contrato Número

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PPB Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the SSBCI Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.   |

ADMINISTRACION DE  
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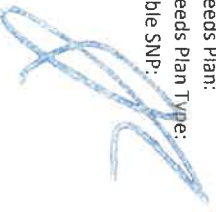
# Bid Reports 2024

## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
H5577 - 054 1  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically III: No  
Part D Senior Savings Model: No

Region:  
Lead Marketing Region:  
Org. Marketing Name:  
Plan Name:  
Plan Geographic Name:  
Segment ID:  
Segment Geographic Name:  
Status:

New York  
New York  
MCS Classicare  
MCS Classicare Platino Maximo (HMO D-SNP)  
Puerto Rico  
1  
Region 1  
Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)  
HMO  
Part A and Part B  
N/A  
No  
US - No  
Yes, 00024446  
Yes, Defined Standard  
Yes  
Dual-Eligible  
Medicare non-zero dollar cost sharing plan



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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes

Standard Bid For Section B:  
Standard Bid For Section C:  
Standard Bid For Section D:

No  
No  
No

**Part D Benefit Data**

| Benefit  | Plan Data  |
|--|--|
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  |  |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program   | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.             |
| Indicate which tiers have insulin drugs (Select all that apply):                           |  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00   |

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|   |   |
|---|---|
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply: | \$35.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply: | \$35.00   |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply: | \$35.00   |
| Vaccine Attestation:  | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold   |   |

| General Data  |           |
|---|-----------|
| Benefit   | Plan Data |
| All drugs on formulary available at extended days supply                                  | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill? | Yes       |
| Standard Retail Cost-sharing, 1 Month =   | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =  | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =  | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =  | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =  | 90 Days   |
| Long Term Care Pharmacy, 1 Month =  | 31 Days   |

NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold

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 Contrato Número

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VBID - Part D Benefit Data

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



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# Bid Reports 2024

## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
H5577 - 054 2  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 2  
Segment Geographic Name: Region 2  
Status: Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)  
HMO  
Part A and Part B  
N/A  
No  
US - No  
Yes, 00024446  
Yes, Defined Standard  
Yes  
Dual-Eligible  
Medicare non-zero dollar cost sharing plan



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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes

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

| Part D Benefit Data  |  |
|--|--|
| <b>Benefit</b>   | <b>Plan Data</b>   |
| Deductible   | 545.00   |
| Pre-IOL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  | No   |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program   | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.             |
| Indicate which tiers have Insulin drugs (Select all that apply):                           |  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00   |

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|   |   |
|---|---|
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply: | \$35.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply: | \$35.00   |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply: | \$35.00   |
| Vaccine Attestation:  | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold   |   |

| General Data  |           |
|---|-----------|
| Benefit   | Plan Data |
| All drugs on formulary available at extended days supply                                  | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill? | Yes       |
| Standard Retail Cost-sharing, 1 Month =   | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =  | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =  | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =  | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =  | 90 Days   |
| Long Term Care Pharmacy, 1 Month =  | 31 Days   |

NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold





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

ADMINISTRACION DE  
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Contrato Número

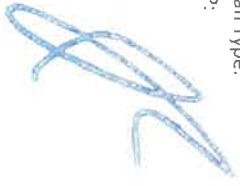
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# Bid Reports 2024

## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
H5577 - 054 3  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 3  
Segment Geographic Name: Region 3  
Status: Version 2 - Renewal - Successfully exported to desk review (06/06/23)  
HMO  
Part A and Part B  
N/A  
No  
US - No  
Yes, 00024446  
Yes, Defined Standard  
Yes  
Dual-Eligible  
Medicare non-zero dollar cost sharing plan



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Contrato Número

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes

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

Part D Benefit Data

| Benefit  | Plan Data  |
|--|--|
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  | No   |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program   | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.             |
| Indicate which tiers have insulin drugs (Select all that apply):                           |  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00   |

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AGENCIACIÓN DE SERVICIOS DE SALUD

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|   |   |
|---|---|
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply: | \$35.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply: | \$35.00   |
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply: | \$35.00   |
| Vaccine Attestation:  | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold   |   |

| General Data  |           |
|---|-----------|
| Benefit   | Plan Data |
| All drugs on formulary available at extended days supply                                  | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill? | Yes       |
| Standard Retail Cost-sharing, 1 Month =   | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =  | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =  | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =  | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =  | 90 Days   |
| Long Term Care Pharmacy, 1 Month =  | 31 Days   |

NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold



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

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**Bid Reports 2024**

**Plan Service Area Report**

MCS ADVANTAGE, INC.  
 HS577 - 054 1  
 Valid: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Planos Maximo (HMO D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Segment ID: 1  
 Segment Geographic Name: Region 1  
 Status: Version 2 - Renewal - Successfully exported to desk review (06/05/23)

Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$0.00  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 00024445  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Dual-Eligible Medicare non-zero dollar cost sharing plan: Yes

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

| State       | County    | County Code | Employer-Only County? | Pending County? | Partial County?  |
|-------------|-----------|-------------|-----------------------|-----------------|--|
| Puerto Rico | Aguada    | 40020       | No                    | No              | No<br>Zipcode(s): 00602                                    |
| Puerto Rico | Aguadilla | 40030       | No                    | No              | No<br>Zipcode(s): 00603, 00604, 00605, 00690               |
| Puerto Rico | Arecibo   | 40060       | No                    | No              | No<br>Zipcode(s): 00610, 00670                             |
| Puerto Rico | Arecibo   | 40070       | No                    | No              | No<br>Zipcode(s): 00612, 00613, 00614, 00616, 00652, 00688 |
| Puerto Rico | Camuy     | 40140       | No                    | No              | No<br>Zipcode(s): 00627, 00670                             |

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|             |               |       |    |    |    |    |                                 |
|-------------|---------------|-------|----|----|----|----|---------------------------------|
| Puerto Rico | Hatillo       | 40320 | No | No | No | No | Zipcode(s): 00659               |
| Puerto Rico | Isabela       | 40350 | No | No | No | No | Zipcode(s): 00659               |
| Puerto Rico | Mayaguez      | 40380 | No | No | No | No | Zipcode(s): 00662               |
| Puerto Rico | Poca          | 40390 | No | No | No | No | Zipcode(s): 00680; 00681; 00682 |
| Puerto Rico | Quebradillas  | 40570 | No | No | No | No | Zipcode(s): 00676               |
| Puerto Rico | Rincon        | 40580 | No | No | No | No | Zipcode(s): 00678               |
| Puerto Rico | San Sebastian | 40660 | No | No | No | No | Zipcode(s): 00677               |
| Puerto Rico | Utuado        | 40710 | No | No | No | No | Zipcode(s): 00685               |
| Puerto Rico |               |       |    |    |    |    | Zipcode(s): 00611; 00641        |

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**Bid Reports 2024**

**Plan Service Area Report**

MCS ADVANTAGE, INC.  
 HES77 - 054 2  
 VBD: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Platino Maximo (HMO-D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Segment ID: 2  
 Segment Geographic Name: Region 2  
 Status: Version 2 - Renewal - Successfully exported to desk review (06/06/23)  
 Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$0.00  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 00024446  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Special Needs Plan Type: Dual-Eligible  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
 Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

| State       | County      | County Code | Employer-Only County? | Pending County? | Partial County? |
|-------------|-------------|-------------|-----------------------|-----------------|-----------------|
| Puerto Rico | Adjuntas    | 40110       | No                    | No              | No              |
| Puerto Rico | Barceloneta | 40090       | No                    | No              | No              |
| Puerto Rico | Cabo Rojo   | 40120       | No                    | No              | No              |
| Puerto Rico | Ciales      | 40190       | No                    | No              | No              |

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|             |               |       |    |    |    |    |                          |
|-------------|---------------|-------|----|----|----|----|--------------------------|
| Puerto Rico | Corozal       | 40230 | No | No | No | No | Zipcode(s): 00783        |
| Puerto Rico | Florida       | 40255 | No | No | No | No | Zipcode(s): 00783        |
| Puerto Rico | Guánica       | 40270 | No | No | No | No | Zipcode(s): 00650        |
| Puerto Rico | Hormigueros   | 40330 | No | No | No | No | Zipcode(s): 00647, 00653 |
| Puerto Rico | Jayuya        | 40360 | No | No | No | No | Zipcode(s): 00660        |
| Puerto Rico | Lajas         | 40390 | No | No | No | No | Zipcode(s): 00664        |
| Puerto Rico | Lares         | 40400 | No | No | No | No | Zipcode(s): 00667        |
| Puerto Rico | Las Marías    | 40410 | No | No | No | No | Zipcode(s): 00631, 00669 |
| Puerto Rico | Manatí        | 40450 | No | No | No | No | Zipcode(s): 00670        |
| Puerto Rico | Maricao       | 40460 | No | No | No | No | Zipcode(s): 00674        |
| Puerto Rico | Maricao       | 40460 | No | No | No | No | Zipcode(s): 00674        |
| Puerto Rico | Maricao       | 40500 | No | No | No | No | Zipcode(s): 00606        |
| Puerto Rico | Orocovis      | 40530 | No | No | No | No | Zipcode(s): 00687        |
| Puerto Rico | Sabana Grande | 40610 | No | No | No | No | Zipcode(s): 00720        |
| Puerto Rico | San German    | 40630 | No | No | No | No | Zipcode(s): 00637        |
| Puerto Rico | Vega Alta     | 40720 | No | No | No | No | Zipcode(s): 00636, 00683 |
| Puerto Rico | Vega Baja     | 40730 | No | No | No | No | Zipcode(s): 00692, 00694 |
| Puerto Rico | Yauco         | 40770 | No | No | No | No | Zipcode(s): 00693, 00694 |
| Puerto Rico | Yauco         | 40770 | No | No | No | No | Zipcode(s): 00698        |

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**Bid Reports 2024**

**Plan Service Area Report**

MCS ADVANTAGE, INC  
 H5577 - 054 3  
 Vbld: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classicare  
 Plan Name: MCS Classicare Planio Marino (HMO D-SNP)  
 Plan Geographic Name: Puerto Rico  
 Segment ID: 3  
 Segment Geographic Name: Region 3  
 Status: Version 2 - Renewal - Successfully exported to desk review (05/06/23)

Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$0.00  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, 0002446  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Special Needs Plan Type: Dual Eligible  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
 Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes

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

| State       | County       | County Code | Employer-Only County? | Pending County? | Partial County?          |
|-------------|--------------|-------------|-----------------------|-----------------|--------------------------|
| Puerto Rico | Aguas Buenas | 40040       | No                    | No              | No                       |
| Puerto Rico | Abonito      | 40050       | No                    | No              | Zipcode(s): 00703        |
| Puerto Rico | Arroyo       | 40080       | No                    | No              | Zipcode(s): 00705, 00766 |
| Puerto Rico | Barranquitas | 40100       | No                    | No              | Zipcode(s): 00714        |
| Puerto Rico |              |             |                       |                 | Zipcode(s): 00794        |

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Contrato Número

|             |            |       |    |    |    |    |    |   |
|-------------|------------|-------|----|----|----|----|----|---|
| Puerto Rico | Bayamon    | 40110 | No | No | No | No | No | Zipcode(s): 00934; 00956; 00957; 00958; 00959; 00960; 00951               |
| Puerto Rico | Caguas     | 40130 | No | No | No | No | No | Zipcode(s): 00725; 00726; 00727   |
| Puerto Rico | Camaguey   | 40145 | No | No | No | No | No | Zipcode(s): 00729; 00745  |
| Puerto Rico | Carolina   | 40150 | No | No | No | No | No | Zipcode(s): 00979; 00981; 00982; 00983; 00984; 00985; 00986; 00987; 00988 |
| Puerto Rico | Cataño     | 40160 | No | No | No | No | No | Zipcode(s): 00962; 00963  |
| Puerto Rico | Cayey      | 40170 | No | No | No | No | No | Zipcode(s): 00736; 00737  |
| Puerto Rico | Celiba     | 40180 | No | No | No | No | No | Zipcode(s): 00735; 00742  |
| Puerto Rico | Cidra      | 40200 | No | No | No | No | No | Zipcode(s): 00739   |
| Puerto Rico | Coamo      | 40210 | No | No | No | No | No | Zipcode(s): 00759   |
| Puerto Rico | Comerio    | 40220 | No | No | No | No | No | Zipcode(s): 00782   |
| Puerto Rico | Culebra    | 40240 | No | No | No | No | No | Zipcode(s): 00775   |
| Puerto Rico | Dorado     | 40250 | No | No | No | No | No | Zipcode(s): 00646   |
| Puerto Rico | Fajardo    | 40260 | No | No | No | No | No | Zipcode(s): 00738; 00740  |
| Puerto Rico | Guayama    | 40280 | No | No | No | No | No | Zipcode(s): 00704; 00784; 00785   |
| Puerto Rico | Guayanilla | 40290 | No | No | No | No | No | Zipcode(s): 00655; 00785  |
| Puerto Rico | Guaynabo   | 40300 | No | No | No | No | No | Zipcode(s): 00934; 00965; 00966; 00968; 00969; 00970; 00971               |
| Puerto Rico | Gurabo     | 40310 | No | No | No | No | No | Zipcode(s): 00778   |
| Puerto Rico | Humacao    | 40340 | No | No | No | No | No | Zipcode(s): 00741; 00743; 00791; 00792                                    |

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|             |              |       |    |    |    |    |   |
|-------------|--------------|-------|----|----|----|----|---|
| Puerto Rico | Juana Diaz   | 40370 | No | No | No | No | Zipcode(s): 00795   |
| Puerto Rico | Juncos       | 40380 | No | No | No | No | Zipcode(s): 00795   |
| Puerto Rico | Las Piedras  | 40420 | No | No | No | No | Zipcode(s): 00777   |
| Puerto Rico | Lobos        | 40430 | No | No | No | No | Zipcode(s): 00771   |
| Puerto Rico | Lugaillo     | 40440 | No | No | No | No | Zipcode(s): 00772   |
| Puerto Rico | Mauabo       | 40470 | No | No | No | No | Zipcode(s): 00773   |
| Puerto Rico | Megabus      | 40510 | No | No | No | No | Zipcode(s): 00707   |
| Puerto Rico | Naranjo      | 40570 | No | No | No | No | Zipcode(s): 00718; 00744  |
| Puerto Rico | Pailitas     | 40540 | No | No | No | No | Zipcode(s): 00719   |
| Puerto Rico | Penuelas     | 40550 | No | No | No | No | Zipcode(s): 00723   |
| Puerto Rico | Ponce        | 40560 | No | No | No | No | Zipcode(s): 00624   |
| Puerto Rico | Rio Grande   | 40590 | No | No | No | No | Zipcode(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732; 00733; 00734; 00780  |
| Puerto Rico | Salinas      | 40620 | No | No | No | No | Zipcode(s): 00721; 00745  |
| Puerto Rico | San Juan     | 40640 | No | No | No | No | Zipcode(s): 00704; 00751  |
| Puerto Rico | San Lorenzo  | 40650 | No | No | No | No | Zipcode(s): 00901; 00902; 00905; 00906; 00907; 00908; 00909; 00910; 00911; 00912; 00913; 00914; 00915; 00916; 00917; 00918; 00919; 00920; 00921; 00922; 00923; 00924; 00925; 00926; 00927; 00928; 00929; 00930; 00931; 00932; 00933; 00934; 00935; 00936; 00937; 00938; 00939; 00940; 00955; 00975; 00976; 00979; 00981 |
| Puerto Rico | Santa Isabel | 40670 | No | No | No | No | Zipcode(s): 00754   |
| Puerto Rico | Toa Alta     | 40680 | No | No | No | No | Zipcode(s): 00757   |
| Puerto Rico |              |       | No | No | No | No | Zipcode(s): 00953; 00954  |

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|             |               |       |    |    |    |    |  |
|-------------|---------------|-------|----|----|----|----|--|
| Puerto Rico | Toa Baja      | 40690 | No | No | No | No | Zipcode(s): 00949; 00950; 00951; 00952 |
| Puerto Rico | Trujillo Alto | 40700 | No | No | No | No | Zipcode(s): 00976; 00977; 00978        |
| Puerto Rico | Veques        | 40740 | No | No | No | No | Zipcode(s): 00765                      |
| Puerto Rico | Vitalba       | 40750 | No | No | No | No | Zipcode(s): 00766                      |
| Puerto Rico | Yabucoa       | 40760 | No | No | No | No | Zipcode(s): 00767                      |

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Contrato Número

# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.  
H5577 - 054 - 1  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

|                                   |  |
|-----------------------------------|--|
| Region:                           | New York   |
| Lead Marketing Region:            | New York   |
| Org: Marketing Name:              | MCS Classicare   |
| Plan Name:                        | MCS Classicare Platino Maximo (HMO D-SNP)                                |
| Plan Geographic Name:             | Puerto Rico  |
| Segment ID:                       | Region 1   |
| Segment Geographic Name:          | Version 2 - Renewal - Successfully exported to desk review<br>(06/06/23) |
| Status:                           | HMO  |
| Plan Type:                        | Part A and Part B  |
| Enrollee Type:                    | \$0.00   |
| Part C Plan Premium:              | N/A  |
| Part D Plan Premium:              | No   |
| Continuation Area Available:      | US - No  |
| Visitor/Travel Benefit Available: | Yes, 00024446  |
| Formulary:                        | Yes, Defined Standard  |
| Part D Benefit:                   | Yes  |
| Special Needs Plan:               | Dual-Eligible  |
| Special Needs Plan Type:          | Medicare non-zero dollar cost sharing plan                               |
| Dual-Eligible SNP:                |  |

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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

| Plan Level Cost Shares and Limits   |                                      |
|---|--------------------------------------|
| Question  | Response                             |
| Is there an In-Network Plan Deductible?   | No                                   |
| 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 Lower, Intermediate or Mandatory Level?    | Lower                                |
| 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                                  |

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|  |  |
|--|--|
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e: 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |
|--|--|

|   |                 |
|---|-----------------|
| <b>Reductions in Cost Sharing - General</b> |                 |
| <b>Question</b>                             | <b>Response</b> |
| Do you offer Reductions in Cost Sharing?    | No              |

|   |                              |
|---|------------------------------|
| <b>Combined Benefits - General</b>  |                              |
| <b>Question</b>   | <b>Response</b>              |
| Do you offer Combined Supplemental Benefits?                                  | Yes                          |
| Select the number of Combined Supplemental Benefit packages you are offering? | 2                            |
| Combined Benefits Group 1 Name:   | Combined Eyewear and Hearing |




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|  |  |
|--|--|
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 600.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No   |
| Combined Benefits Group 2 Name:  | Combined Transportation  |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBI/UF/SSBCI                         |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Transportation provided by contracted vendors.   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No   |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes  |
| Indicate number of shared visits:  | 12   |
| Select visit limit periodicity:  | Every year   |

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# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.  
H5577 - 054 - 2  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Orig. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 2  
Segment Geographic Name: Region 2

Status: Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)  
Plan Type: HMO  
Enrollee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Dual-Eligible: Dual-Eligible  
Medicare non-zero dollar cost sharing plan

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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
 Standard Bid For Section B: No  
 Standard Bid For Section C: No  
 Standard Bid For Section D: No

| Plan Level Cost Shares and Limits   |                                      |
|---|--------------------------------------|
| Question  | Response                             |
| Is there an In-Network Plan Deductible?   | No                                   |
| 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 Lower, Intermediate or Mandatory Level?    | Lower                                |
| 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                                  |

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|   |   |
|---|---|
| <p>Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount:</p> | <p>1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services</p> |
|---|---|

|   |                 |
|---|-----------------|
| <b>Reductions in Cost Sharing - General</b> |                 |
| <b>Question</b>                             | <b>Response</b> |
| Do you offer Reductions in Cost Sharing?    | No              |

|   |                              |
|---|------------------------------|
| <b>Combined Benefits - General</b>  |                              |
| <b>Question</b>   | <b>Response</b>              |
| Do you offer Combined Supplemental Benefits?                                  | Yes                          |
| Select the number of Combined Supplemental Benefit packages you are offering? | 2                            |
| Combined Benefits Group 1 Name:   | Combined Eyewear and Hearing |




  
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|  |  |
|--|--|
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 600.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No   |
| Combined Benefits Group 2 Name:  | Combined Transportation  |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBI/D/U/F/SSBCI                      |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Transportation provided by contracted vendors.   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No   |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes  |
| Indicate number of shared visits:  | 12   |
| Select visit limit periodicity:  | Every year   |

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# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.  
H5577 - 054 - 3  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Maximo (HMO D-SNP)  
Plan Geographic Name: Puerto Rico  
Segment ID: 3  
Segment Geographic Name: Region 3  
Status: Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)  
Plan Type: HMO  
Enrollee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Dual-Eligible SNP: Dual-Eligible  
Medicare non-zero dollar cost sharing plan



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Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?      Yes  
 Standard Bid For Section B:      No  
 Standard Bid For Section C:      No  
 Standard Bid For Section D:      No

| Plan Level Cost Shares and Limits   |                                      |
|---|--------------------------------------|
| Question  | Response                             |
| Is there an In-Network Plan Deductible?   | No                                   |
| 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 Lower, Intermediate or Mandatory Level?    | Lower                                |
| 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                                  |

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|  |  |
|--|--|
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |
|--|--|



|   |          |
|---|----------|
| <b>Reductions in Cost Sharing - General</b> |          |
| Question                                    | Response |
| Do you offer Reductions in Cost Sharing?    | No       |

|   |                              |
|---|------------------------------|
| <b>Combined Benefits - General</b>  |                              |
| Question  | Response                     |
| Do you offer Combined Supplemental Benefits?                                  | Yes                          |
| Select the number of Combined Supplemental Benefit packages you are offering? | 2                            |
| Combined Benefits Group 1 Name:   | Combined Eyewear and Hearing |



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|  |  |
|--|--|
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 600.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No   |
| Combined Benefits Group 2 Name:  | Combined Transportation  |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBIID/UF/SSBCI                       |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Transportation provided by contracted vendors.   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No   |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes  |
| Indicate number of shared visits:  | 12   |
| Select visit limit periodicity:  | Every year   |

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ADMINISTRACION DE  
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**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                     |       |                       |   |                            |     |                  |
|---------------------|-------|-----------------------|---|----------------------------|-----|------------------|
| 1. Contract Number: | H5577 | 5. Organization Name: | MCS ADVANTAGE, INC.<br>MCS Classicare Platinio Maximo (HMO D-SNP) | 9. Enrollee Type:          | A/B | 13. Region Name: |
| 2. Plan ID:         | 054   | 6. Plan Name:         | HMO   | 10. MA Region:             | N/A |                  |
| 3. Segment ID:      | 001   | 7. Plan Type:         | Y   | 11. Act. Swap/Equiv Apply: | N   |                  |
| 4. Contract Year:   | 2024  | 8. MA-PD:             |   | 12. SNP:                   | Y   | 14. SNP Type:    |

**II. Other Information**

|   |          |  |          |
|---|----------|--|----------|
| <b>A. Part B Information</b>                  |          | <b>B. Rebate Allocation for Part B Premium</b>                         |          |
| 1. Maximum Pt B premium buydown amt., per CMS | \$164.90 | 1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)  | \$100.00 |
|   |          | 2. Part B Rebate Allocation, rounded to one decimal (see instructions) | \$100.00 |

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Contrato Número

**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                     |       |                       |  |                            |     |                  |
|---------------------|-------|-----------------------|--|----------------------------|-----|------------------|
| 1. Contract Number: | H5577 | 5. Organization Name: | MCS ADVANTAGE, INC.<br>MCS Classicare Platino Maximo (HMO D-SNP) | 9. Enrollee Type:          | A/B | 13. Region Name: |
| 2. Plan ID:         | 054   | 6. Plan Name:         | HMO  | 10. MA Region:             | N/A |                  |
| 3. Segment ID:      | 002   | 7. Plan Type:         | Y  | 11. Act. Swap/Equiv Apply: | N   |                  |
| 4. Contract Year:   | 2024  | 8. MA-PD:             |  | 12. SNP:                   | Y   | 14. SNP Type:    |

**II. Other Information**

|   |          |  |          |
|---|----------|--|----------|
| <b>A. Part B Information</b>                  |          | <b>B. Rebate Allocation for Part B Premium</b>                         |          |
| 1. Maximum Pt B premium buydown amt., per CMS | \$164.90 | 1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)  | \$100.00 |
|   |          | 2. Part B Rebate Allocation, rounded to one decimal (see instructions) | \$100.00 |

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**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                     |       |                       |  |                            |     |                  |
|---------------------|-------|-----------------------|--|----------------------------|-----|------------------|
| 1. Contract Number: | HS577 | 5. Organization Name: | MCS ADVANTAGE, INC.<br>MCS Classicare Platino Maximo (HMO D-SNP) | 9. Enrollee Type:          | A/B | 13. Region Name: |
| 2. Plan ID:         | 054   | 6. Plan Name:         | HMO  | 10. MA Region:             | N/A |                  |
| 3. Segment ID:      | 003   | 7. Plan Type:         | HMO  | 11. Act. Swap/Equiv Apply: | N   |                  |
| 4. Contract Year:   | 2024  | 8. MA-PD:             | Y  | 12. SNP:                   | Y   | 14. SNP Type:    |

**II. Other Information**

|   |          |  |           |
|---|----------|--|-----------|
| <b>A. Part B Information</b>                  |          | <b>B. Rebate Allocation for Part B Premium</b>                         |           |
| 1. Maximum Pt B premium buydown amt., per CMS | \$164.90 | 1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)  | \$ 100.00 |
|   |          | 2. Part B Rebate Allocation, rounded to one decimal (see instructions) | \$100.00  |

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# Appendix C-1

## Plan Benefit Package (PBP)

### H5577 – 055

*EMR*

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# Bid Reports 2024

## PBP Benefits Report

MCS ADVANTAGE, INC.

H5577 - 055

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Del Sur (HMO D-SNP)  
Plan Geographic Name: Puerto Rico South 8  
Segment ID: 0  
Segment Geographic Name: null  
Status: Version 2 - Renewal - Successfully exported to desk review (06/06/23)  
Plan Type: HMO  
Employee Type: Part A and Part B  
Part C Plan Premium: \$0.00  
Part D Plan Premium: N/A  
Continuation Area Available: No  
Visitor/Travel Benefit Available: US - No  
Formulary: Yes, 00024446  
Part D Benefit: Yes, Defined Standard  
Special Needs Plan: Yes  
Special Needs Plan Type: Dual-Eligible  
Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes  
Standard Bid For Section B: No  
Standard Bid For Section C: No  
Standard Bid For Section D: No

### Plan Level Data

Question

Response

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**Tiered Cost sharing for Part B Services**

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

|                                     |  |
|-------------------------------------|--|
| <b>1a Inpatient Hospital-Acute</b>  |  |
| <b>Service Category Description</b> |  |
| <b>Benefit Description</b>          |  |

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

|                                     |                 |
|-------------------------------------|-----------------|
| <b>Question</b>                     | <b>Response</b> |
| <b>1a Inpatient Hospital-Acute</b>  |                 |
| <b>Service Category Description</b> |                 |
| <b>Benefit Description</b>          |                 |

|  |  |
|--|--|
| <b>1b Inpatient Hospital-Psychiatric</b> |  |
| <b>Service Category Description</b>      |  |
| <b>Benefit Description</b>               |  |

|   |                 |
|---|-----------------|
| <b>Question</b>   | <b>Response</b> |
| Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? | No              |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                      | No              |

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**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care? | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| What is your Inpatient Hospital Psychiatric benefit period?   | Original Medicare   |
| Is authorization required?  | Yes   |
| Is a referral required for Inpatient Psychiatric Hospital Services?   | No  |
| Notes:  | Preauthorization required through MCS Solutions, except for Emergency and Urgency Services. |

**1b Inpatient Hospital-Psychiatric**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

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**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

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

**2 Skilled Nursing Facility (SNF)**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

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**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

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

**3 Cardiac and Pulmonary Rehabilitation Services**

**Service Category Description**

**Benefit Description**

| Question                     | Response |
|------------------------------|----------|
| 4a Emergency Services        |          |
| Service Category Description |          |
| Benefit Description          |          |

**Service Category Description**

**Benefit Description**

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

**4a Emergency Services**

**Service Category Description**

**Benefit Description**

| Question                     | Response |
|------------------------------|----------|
| 4b Urgently Needed Services  |          |
| Service Category Description |          |
| Benefit Description          |          |

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**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**4b Urgently Needed Services**  
**Service Category Description**

| Benefit Description  | Response |
|--|----------|
| <b>Question</b>  |          |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? | No       |
| Is there an enrollee Coinsurance?                                | No       |
| Is there an enrollee Copayment?                                  | No       |

**4c Worldwide Emergency/Urgent Coverage**  
**Service Category Description**

| Benefit Description   | Response   |
|---|--|
| <b>Question</b>   |  |
| Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefit:  | Worldwide Emergency Coverage; Worldwide Urgent Coverage  |
| Select type of benefit for Worldwide Emergency Coverage:  | Mandatory  |
| Select type of benefit for Worldwide Urgent Coverage:   | Mandatory  |
| Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?          | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                  | No   |
| Is there an enrollee Coinsurance?   | No   |
| Is there an enrollee Copayment?   | No   |
| Indicate Minimum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Emergency Coverage:                               | \$0.00   |
| Indicate Minimum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Indicate Maximum Copayment amount for Worldwide Urgent Coverage:                                  | \$0.00   |
| Is there an enrollee Deductible?  | No   |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |
| Notes:  | Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share. |

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**5 Partial Hospitalization**

**Service Category Description**

**Benefit Description**

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

**6 Home Health Services**

**Service Category Description**

**Benefit Description**

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

**7a Primary Care Physician Services**

**Service Category Description**

**Benefit Description**

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

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**7b Chiropractic Services**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Chiropractic Services as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Care        |
| Select type of benefit for Routine Care:  | Mandatory           |
| Is this benefit unlimited for Routine Care?   | No, indicate number |
| Indicate number of visits for Routine Care:   | 6                   |
| Select Routine Care periodicity:  | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                   | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                    | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:                    | \$0.00              |
| Indicate Minimum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Indicate Maximum Copayment amount per visit for Routine Care:                       | \$0.00              |
| Is there an enrollee Deductible?  | No                  |
| Is authorization required?  | No                  |
| Is a referral required for Chiropractic Services?                                   | Yes                 |

**7c Occupational Therapy Services**

**Service Category Description**

**Benefit Description**

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

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**7d Physician Specialist Services excluding Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7e Mental Health Specialty Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?             | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |
| Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:  | \$0.00   |
| Indicate Minimum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Group Sessions:       | \$0.00   |
| Is authorization required?   | Yes  |
| Is a referral required for Mental Health Specialty Services - Non-Physician? | No   |
| Notes:   | <p>ADMINISTRACION DE SERVICIOS DE SALUD</p> <p>CONTRATO NÚMERO 24-0004</p> |

**7f Podiatry Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

**7f Podiatry Services**

**Service Category Description**  
**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Podiatry Services as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Foot Care   |
| Select type of benefit for Routine Foot Care:                                   | Mandatory   |
| Is this benefit unlimited for Routine Foot Care?                                | No  |
| Indicate number of Routine Foot Care visits:                                    | 1   |
| Select the Routine Foot Care periodicity:                                       | Every three months  |
| Is there a service-specific Maximum Plan Benefit Coverage amount?               | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00  |
| Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:      | \$0.00  |
| Indicate Minimum Copayment amount per visit for Routine Foot Care:              | \$0.00  |
| Indicate Maximum Copayment amount per visit for Routine Foot Care:              | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Podiatry Services?                                   | Yes   |
| Notes:  | Routine foot care will be provided in the home by trained foot professionals. |

**7g Other Health Care Professional Services**

**Service Category Description**  
**Benefit Description**

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

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**7g Other Health Care Professional Services**

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is a referral required for Other Health Care Professional Services? | Yes      |

**7h Psychiatric Services**

**Service Category Description**

**Benefit Description**

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

**7i Physical Therapy and Speech-Language Pathology Services**

**Service Category Description**

**Benefit Description**

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

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**7j Additional Telehealth Benefits**

**Service Category Description**  
**Benefit Description**

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

**7k Opioid Treatment Program Services**

**Service Category Description**  
**Benefit Description**

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

**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

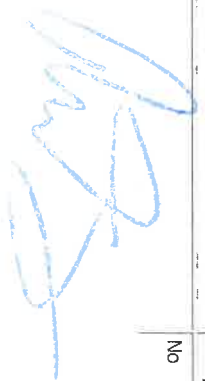
**Service Category Description**  
**Benefit Description**

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

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**8a Outpatient Diagnostic Procedures, Tests and Lab Services**

**Service Category Description**

**Benefit Description**

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

**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

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

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**8b Outpatient Diagnostic and Therapeutic Radiological Services**

**Service Category Description**

**Benefit Description**

| Question   | Response |
|--|----------|
| Is authorization required?   | Yes      |
| Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services? | Yes      |

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

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

**9a Outpatient Hospital Services**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|----------|----------|

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**9b Ambulatory Surgical Center (ASC) Services**

**Service Category Description**

**Benefit Description**

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

**9c Outpatient Substance Abuse Services**

**Service Category Description**

**Benefit Description**

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

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**9d Outpatient Blood Services**  
**Service Category Description**

**Benefit Description**

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

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**9d Outpatient Blood Services**

**Service Category Description**

**Benefit Description**

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

**10a Ambulance Services**

**Service Category Description**

**Benefit Description**

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

**10b Transportation Services**

**Service Category Description**

**Benefit Description**

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

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**10b Transportation Services**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| Select type of benefit for Plan Approved Health-related Location:                        | Mandatory  |
| Is this benefit unlimited for number of trips for Plan Approved Health-related Location? | No   |
| Indicate number of trips for Plan Approved Health-related Location:                      | 12   |
| Select Plan Approved Health-related Location Trips periodicity:                          | Every year   |
| Select Type of Transportation for Plan Approved Health-related Location:                 | One-way  |
| Select Mode of Transportation for Plan Approved Health-related Location:                 | Medical Transport; Other, Describe   |
| Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                        | No   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                         | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Deductible?   | No   |
| Is there an enrollee Copayment?  | No   |
| Is authorization required?   | No   |
| Is a referral required for Transportation Services?                                      | No   |
| Notes:   | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 1314 - Transportation for Non-Medical Needs. |

**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

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

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**11a Durable Medical Equipment (DME)**

**Service Category Description**

**Benefit Description**

**Question**

Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

**Response**

**11b Prosthetics/Medical Supplies**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:

Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:

Is authorization required?

Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

Is there an enrollee Coinsurance?

Is there an enrollee Deductible?

Is there an enrollee Copayment?

Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:

Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:

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

**Service Category Description**

**Benefit Description**

| <b>Question</b>  | <b>Response</b>   |
|--|---|
| Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts: | \$0.00  |
| Do you limit Diabetic Supplies and Services to those from specified manufacturers?                     | Yes   |
| Is authorization required?   | Yes   |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |
| Notes:   | Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. |

**12 Dialysis Services**

**Service Category Description**

**Benefit Description**

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

| <b>Question</b>   | <b>Response</b>                     |
|---|-------------------------------------|
| Does the plan provide Acupuncture as a supplemental benefit under Part C? | Yes                                 |
| Select enhanced benefit:  | ADMINISTRACION DE SEGUROS DE SALUD. |
| Select type of benefit for Number of Treatments:                          | Mandatory                           |

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**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Is this benefit unlimited for Number of Treatments?

No

Indicate limit for Number of Treatments:

6

Indicate Number of Treatments periodicity:

Every year

Is there a service-specific Maximum Plan Benefit Coverage amount?

No

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

No

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

**13a Acupuncture**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13b Over-the-Counter (OTC) Items**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?

No

**13c Meal Benefit**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**13c Meal Benefit**

**Service Category Description**

**Benefit Description**

**Question**

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.

**Response**

No

**13d Other 1**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13e Other 2**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13f Other 3**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13g Dual Eligible SNPs with Highly Integrated Services**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

**13i Non-Primarily Health Related Benefits for the Chronically III**

**Service Category Description**

**Benefit Description**

**Question**

**Response**

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**14a Medicare-covered Zero Cost-Sharing Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

Medicare-covered Zero Dollar Preventive Services Attestation

**Response**

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

Is authorization required?

No

Is a referral required?

No

**14a Medicare-covered Zero Cost-Sharing Preventive Services**

**Service Category Description**

**Benefit Description**

**Question**

14b Annual Physical Exam

**Service Category Description**

**Benefit Description**

**Question**

Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?

**Response**

No

**14c Other Defined Supplemental Benefits**

**Service Category Description**

**Benefit Description**

**Question**

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

**Response**

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

Select type of benefit for Health Education:

Mandatory

Select type of benefit for Nutritional/Dietary Benefit:

Mandatory

Is this benefit unlimited for Nutritional/Dietary Benefit?

No, indicate number

Indicate number of visits for Nutritional/Dietary Benefit:

6

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**14c Other Defined Supplemental Benefits**

**Service Category Description**

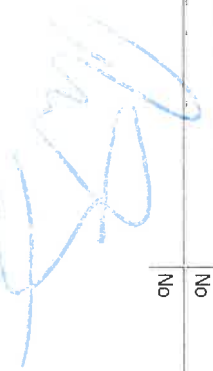
**Benefit Description**

| <b>Question</b>   | <b>Response</b>                               |
|---|---|
| Indicate setting for Nutritional/Dietary Benefit:   | 0   |
| 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 Technologies (Including Web/Phone-based technologies and Nursing Hotline): | Mandatory                                     |
| Select the type of Remote Access Technologies offered (Select all that apply):                                      | Web/Phone-based technologies; Nursing Hotline |
| Select type of benefit for Alternative Therapies:   | Mandatory                                     |
| Is this benefit unlimited for Alternative Therapies?  | No, indicate number                           |
| Indicate number of visits offered for Alternative Therapies:  | 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                                    |
| Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?           | No  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?            | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Health Education:   | \$0.00  |
| Indicate Maximum Copayment amount for Health Education:   | \$0.00  |
| Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Maximum Copayment amount for Fitness Benefit:  | \$0.00  |
| Indicate Minimum Copayment amount for Alternative Therapies:  | \$0.00  |
| Indicate Maximum Copayment amount for Alternative Therapies:  | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Other Defined Supplemental Benefits?   | No  |

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**14c Other Defined Supplemental Benefits**

**Service Category Description**  
**Benefit Description**

| Question  | Response  |
|---|---|
| Nutritional/Dietary Benefit Notes:                              | Personal evaluation and diet plan designed by licensed dietician 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.  |
| 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. Nursing Hotline. |
| Remote Access Technologies (Nursing Hotline) 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. Nursing Hotline. |
| 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.   |

**14d Kidney Disease Education Services**  
**Service Category Description**  
**Benefit Description**

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

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**14e Other Medicare-Covered Preventive Services**  
**Service Category Description**  
**Benefit Description**

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**14e Other Medicare-Covered Preventive Services**

**Service Category Description**

**Benefit Description**

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

**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

| Question | Response |
|----------|----------|
|          |          |

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**15 Medicare Part B Rx Drugs and Home Infusion Drugs**

**Service Category Description**

**Benefit Description**

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

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

Is there an enrollee Coinsurance?  No

Indicate the Minimum Coinsurance percentage for Medicare Part B Chemotherapy/Radiation Drugs:  0%

Indicate Minimum Coinsurance percentage for other Medicare Part B Drugs:  0%

Is there an enrollee Copayment?  No

Is there an enrollee Coinsurance for Insulin?  No

Is there an enrollee Copayment for Insulin?  No

Is there an enrollee Deductible?  No

Is Authorization Required?  Yes

Does the plan offer step therapy?  Yes

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

Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?  No

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

**Service Category Description**

**Benefit Description**

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

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

**Service Category Description**

**Benefit Description**

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

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**1db Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?        | Yes   |
| Select enhanced benefits:   | Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services |
| Select type of benefit for Non-routine Services:  | Mandatory   |
| Is this benefit unlimited for Non-routine Services?   | Yes   |
| Select type of benefit for Diagnostic Services:   | Mandatory   |
| Is this benefit unlimited for Diagnostic Services?  | No, indicate number   |
| Indicate number of visits for Diagnostic Services:  | 1   |
| Select the Diagnostic Services periodicity:   | 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   |
| 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 Oral/Maxillofacial Surgery, Other Services? | Yes   |
| Is there a service-specific Maximum Plan Benefit Coverage amount?                               | Yes   |
| Select the Maximum Plan Benefit Coverage type:  | Plan-specified amount per period  |
| Indicate Maximum Plan Benefit Coverage amount:  | 1000.00   |
| Select the Maximum Plan Benefit Coverage periodicity:   | Every year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |

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

**Service Category Description**

**Benefit Description**

| Question  | Response |
|---|----------|
| Is there an enrollee Copayment?   | No       |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00   |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00   |
| Indicate Minimum Copayment amount for Non-routine Services:   | \$0.00   |
| Indicate Maximum Copayment amount for Non-routine Services:   | \$0.00   |
| Indicate Minimum Copayment amount for Restorative Services:   | \$0.00   |
| Indicate Maximum Copayment amount for Restorative Services:   | \$0.00   |
| Indicate Minimum Copayment amount for Endodontics:  | \$0.00   |
| Indicate Maximum Copayment amount for Endodontics:  | \$0.00   |
| Indicate Minimum Copayment amount for Periodontics:   | \$0.00   |
| Indicate Maximum Copayment amount for Periodontics:   | \$0.00   |
| Indicate Minimum Copayment amount for Extractions:  | \$0.00   |
| Indicate Maximum Copayment amount for Extractions:  | \$0.00   |
| Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00   |
| Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services: | \$0.00   |
| Is authorization required?  | Yes      |
| Is a referral required for Comprehensive Dental Services?   | No       |

**17a Eye Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Does the plan provide Eye Exams as a supplemental benefit under Part C? | Yes                 |
| Select enhanced benefit:  | Routine Eye Exams   |
| Select type of benefit for Routine Eye Exams:                           | Mandatory           |
| Is this benefit unlimited for Routine Eye Exams?                        | No, indicate number |

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**17a Eye Exams**

**Service Category Description  
Benefit Description**

| Question  | Response   |
|---|------------|
| Indicate number of exams for Routine Eye Exams:                   | 1          |
| Select the Routine Eye Exams periodicity:                         | Every year |
| Is there a service-specific Maximum Plan Benefit Coverage amount? | No         |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No         |
| Is there an enrollee Coinsurance?                                 | No         |
| Is there an enrollee Copayment?                                   | No         |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:  | \$0.00     |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:  | \$0.00     |
| Indicate Minimum Copayment amount for Routine Eye Exams:          | \$0.00     |
| Indicate Maximum Copayment amount for Routine Eye Exams:          | \$0.00     |
| Is there an enrollee Deductible?                                  | No         |
| Is authorization required?  | No         |
| Is a referral required for Eye Exams?                             | No         |

**17b Eyewear**

**Service Category Description  
Benefit Description**

| Question  | Response   |
|---|--|
| Does the plan provide Eyewear as a supplemental benefit under Part C? | Yes  |
| Select enhanced benefits:   | Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames |
| Select type of benefit for Contact lenses:                            | Mandatory  |
| Is this benefit unlimited for Contact lenses?                         | Yes  |
| Select type of benefit for Eyeglasses (lenses and frames):            | Mandatory  |
| Is this benefit unlimited for Eyeglasses (lenses and frames)?         | Yes  |
| Select type of benefit for Eyeglass lenses:                           | Mandatory  |
| Is this benefit unlimited for Eyeglass lenses?                        | Yes  |
| Select type of benefit for Eyeglass frames:                           | Mandatory  |
| Is this benefit unlimited for Eyeglass frames?                        | Yes  |

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**17b Eyewear**

**Service Category Description**

**Benefit Description**

| Question  | Response  |
|---|---|
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | Yes   |
| Select the Maximum Plan Benefit Coverage type:                            | Plan-specified amount per period  |
| Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear? | Yes   |
| Indicate Combined Maximum Plan Benefit Coverage amount:                   | 500.00  |
| Select the Combined Maximum Plan Benefit Coverage periodicity:            | Every Year  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No  |
| Is there an enrollee Coinsurance?   | No  |
| Is there an enrollee Deductible?  | No  |
| Is there an enrollee Copayment?   | No  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00  |
| Is authorization required?  | No  |
| Is a referral required for Eyewear?                                       | No  |
| Notes:  | Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available. |

**18a Hearing Exams**

**Service Category Description**

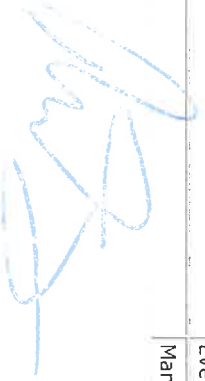
**Benefit Description**

| Question  | Response  |
|---|---|
| Does the plan provide Hearing Exams as a supplemental benefit under Part C? | Yes   |
| Select enhanced benefits:   | Routine Hearing Exams; Fitting/Evaluation for Hearing Aid |
| Select type of benefit for Routine Hearing Exams:                           | Mandatory   |
| Is this benefit unlimited for Routine Hearing Exams?                        | No, indicate number                                       |
| Indicate number for Routine Hearing Exams:                                  | 1   |
| Select Routine Hearing Exams periodicity:                                   | Every Year  |
| Select type of benefit for Fitting/Evaluation for Hearing Aid:              | Mandatory   |

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**18a Hearing Exams**

**Service Category Description**

**Benefit Description**

| Question  | Response            |
|---|---------------------|
| Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?         | No, indicate number |
| Indicate number for Fitting/Evaluation for Hearing Aid:                   | 1                   |
| Select Fitting/Evaluation for Hearing Aid periodicity:                    | Every year          |
| Is there a service-specific Maximum Plan Benefit Coverage amount?         | No                  |
| Is there an enrollee Deductible?  | No                  |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?          | No                  |
| Is there an enrollee Coinsurance?   | No                  |
| Is there an enrollee Copayment?   | No                  |
| Indicate Minimum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Maximum Copayment amount for Medicare-covered Benefits:          | \$0.00              |
| Indicate Minimum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Maximum Copayment amount for Routine Hearing Exams:              | \$0.00              |
| Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: | \$0.00              |
| Is authorization required?  | No                  |
| Is a referral required for Hearing Exams?                                 | No                  |

**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response                 |
|--|--------------------------|
| Does the plan provide Hearing Aids as a supplemental benefit under Part C? | Yes                      |
| Select enhanced benefits:  | Hearing Aids (all types) |
| Select type of benefit for Hearing Aids (all types):                       | Mandatory                |
| Is this benefit unlimited for Hearing Aids (all types)?                    | No, indicate number      |
| Indicate quantity for Hearing Aids (all types):                            | 2                        |
| Select Hearing Aids (all types) periodicity:                               | Every year               |
| Is there a service-specific Maximum Plan Benefit Coverage amount?          | Yes                      |

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**18b Hearing Aids**

**Service Category Description**

**Benefit Description**

| Question   | Response   |
|--|--|
| 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:   | 500.00   |
| Indicate Maximum Plan Benefit Coverage periodicity:                                    | Every Year   |
| Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                       | No   |
| Is there an enrollee Coinsurance?  | No   |
| Is there an enrollee Copayment?  | No   |
| Is there an enrollee Deductible?   | No   |
| Does your plan cover OTC hearing aids as part of your hearing aid benefit?             | No   |
| Is authorization required?   | Yes  |
| Is a referral required for Hearing Aids?   | Yes  |
| Notes:   | Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount. |

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

**Service Category Description**

**Benefit Description**

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

**19a Reduced Cost Sharing for VBIID/UF/SSBCI**

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| Question   | Response |
|--|----------|
| Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits? | No       |
| Do you offer Special Supplemental Benefits for the Chronically Ill?                              | No       |

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**19a Reduced Cost Sharing for VBIID/UF/SSBCI**

| Question   | Response  |
|--|---|
| Are you offering a VBIID Hospice Benefit?  | No  |
| Are you offering Part C benefits under the VBIID Model? (VBIID Part D Rewards and Incentives programs should be entered in Section RX)                           | Yes   |
| In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?  | Value-Based Design Flexibilities by Condition or Socioeconomic Status   |
| WHP Program Type (choose one or more):   | 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?   | 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  |
| Expected Number of Beneficiaries to be Engaged Annually:   | 3085  |
| Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):                           | Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe  |
| Identify actions within your VBIID HEP. (Select all that apply):   | Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its broader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; Assess own infrastructure, resources and ability to support implementation of HEP; Monitor own health equity efforts; Engage enrollees, caregivers, providers and/or communities in health equity efforts |
| Description:<br>  | Analytics tools and Screening and Assessment Tools, namely the Comprehensive Health Risk Screening Tool and MCS HRA Screening; Other, Describe  |
| Identify the screening tool you (the MAO or designated partner) will use to identify HRSNs in your VBIID targeted enrollee populations. (Select all that apply): | Other, Describe   |
| Description:   | MCS utilizes a CHRA, used by network providers for all enrollees that includes screening for HRSN and health literacy and an HRA screening that is used by MCS clinical staff.  |
| Does your VBIID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?   | Yes   |

**19b Additional Benefits for VBIID/UF/SSBCI**

| Question | Response  |
|----------|---|
|          | <p align="center">ADMINISTRACION DE<br/>SEGUROS DE SALUD.</p> <p align="center">№ 2 4 - 0 0 0 4</p> <p align="center">Contrato Número </p> <p align="right">33/43</p> |



**19b Additional Benefits for VBIID/UF/SSBICI**

| Question   | Response |
|--|----------|
| Does your VBIID/MA Uniformity Flexibility/SSBICI benefit offer additional Part C benefits? | No       |
| How many packages do your Additional Benefits contain? (1-15)                              | 1        |

**19b Additional Benefits for VBIID/UF/SSBICI - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category                                | Question   | Response  |
|-------------|---|--|---|
| 19b         | Additional Benefits for VBIID/UF/SSBICI | Is this package applicable to VBIID or MA Uniformity Flexibility or SSBICI?                              | VBIID   |
|             |   | Targeting Methodology - Please choose one or both:   | Socioeconomic Status  |
|             |   | Select LIS reduction level:  | Dual-Eligible Status (for territories)  |
|             |   | Expected Number of Enrollees to be Targeted:   | 3085  |
|             |   | Expected Number of Enrollees to be engaged and receive Model benefits:                                   | 3085  |
|             |   | Does the enrollee need to have all diseases selected to quality?   | No  |
|             |   | Does the enrollee need to have a combination of diseases selected to quality? If yes, describe in notes. | No  |
|             |   | Is there a prerequisite for any additional benefits for this package?                                    | No  |
|             |   | Select all the Non-Medicare-covered additional benefits offered in this package:                         | 131d0: General Supports for Living; 131i: Food and Produce; 1313: Pest Control; 1314: Transportation for Non-Medical Needs; 1315: Indoor Air Quality Equipment and Services; 1316: Social Needs Benefit; 1317: Complementary Therapies; 1318: Services Supporting Self-Direction; 131-O1: Other 1 Non-Primarily Health Related Benefit; 131-O2: Other 2 Non-Primarily Health Related Benefit; 131-O3: Other 3 Non-Primarily Health Related Benefit; 131-O4: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit |
|             |   | Are any benefits exempt from the plan-level deductible?  | No  |
|             |   | Is there a package level maximum coverage amount?  | No  |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category  | Question   | Response  |
|-------------|---|--|---|
| 19b - 13i   | Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes: | Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living |
|             |   | Does the plan provide Food and Produce as a supplemental benefit under Part C?                           | Yes   |
|             |   | Select type of benefit for Food and Produce:   | Mandatory   |
|             |   | Is there a service-specific Maximum Plan Benefit Coverage amount?  | Yes   |
|             |   | Indicate Maximum Plan Benefit Coverage amount:   | 150.00  |
|             |   | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |
|             |   | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?   | No  |
|             |   | Is there an enrollee Coinsurance?  | No  |
|             |   | Is there an enrollee Deductible?   | No  |
|             |   | Is there an enrollee Copayment?  | No  |
|             |   | Is authorization required?   | No  |
|             |   | Is a referral required for Food and Produce?   | No  |
|             |   | Notes:   | Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.  |
|             |   | Does the plan provide Pest Control as a supplemental benefit under Part C?                               | Yes   |
|             |   | Select type of benefit for Pest Control:   | Mandatory   |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                  | No  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                   | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Pest Control?   | No  |
|             |          | Notes:   | Member will choose up to two (2) services per quarter (8 visits annually) for pest control which is combined with home cleaning, any of the Home Assistance services filed in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control Items are covered through the VBID Benefits Card. |
|             |          | Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C? | Yes   |
|             |          | 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?                          | No  |
|             |          | Indicate number of trips for Plan-approved Location:   | 0   |
|             |          | Select Plan-approved Location Trips periodicity:   | Every year  |
|             |          | 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:                     | Van; Medical Transport  |
|             |          | Description:   | Fleet includes sedans, minivans, buses with hydraulic ramps.  |
|             |          | Is this benefit unlimited for number of trips for Any Location?                                    | No  |
|             |          | Indicate number of trips for Any Location:   | 0   |

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

Disease States:

Service Category Description

Benefit Description

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Select Any Location Trips periodicity:  | Every year   |
|             |          | Select Type of Transportation for Non-Medical Needs for Any Location:                                   | One-way  |
|             |          | Select Mode of Transportation for Non-Medical Needs for Any Location:                                   | Van; Medical Transport   |
|             |          | Description:  | Fleet includes sedans, minivans, buses with hydraulic ramps.   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Transportation for Non-Medical Needs?  | No   |
|             |          | Notes:  | Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs. |
|             |          | Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Indoor Air Quality Equipment and Services:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                       | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:  | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:   | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |

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Contrato Número

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response   |
|-------------|----------|--|--|
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Indoor Air Quality Equipment and Services?              | No   |
|             |          | Notes:   | Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card.  |
|             |          | Does the plan provide Social Needs Benefit as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for Social Needs Benefit:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                  | Yes  |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                                     | 0.00   |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                                  | Every month  |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                   | No   |
|             |          | Is there an enrollee Coinsurance?  | No   |
|             |          | Is there an enrollee Deductible?   | No   |
|             |          | Is there an enrollee Copayment?  | No   |
|             |          | Is authorization required?   | No   |
|             |          | Is a referral required for Social Needs Benefit?                                   | No   |
|             |          | Notes:   | Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities. |

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**Contrato Número**

**EMR**



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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question   | Response  |
|-------------|----------|--|---|
|             |          | Does the plan provide Complementary Therapies as a supplemental benefit under Part C?            | Yes   |
|             |          | Select type of benefit for Complementary Therapies:  | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                                 | No  |
|             |          | Is there an enrollee Coinsurance?  | No  |
|             |          | Is there an enrollee Deductible?   | No  |
|             |          | Is there an enrollee Copayment?  | No  |
|             |          | Is authorization required?   | No  |
|             |          | Is a referral required for Complementary Therapies?  | No  |
|             |          | Notes:   | Complementary therapies are covered through the VBID Benefits Card. They are increasingly referred to as integrative medicine, which includes health approaches used to manage symptoms associated with acute and chronic pain. Common complementary health approaches include mind and body interventions such as meditation, spinal manipulation, yoga, massage, tai chi, and acupuncture. A variety of natural products, including herbs, dietary supplements, including probiotic products are also commonly used (NCCIM, 2016a). |
|             |          | Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C? | Yes   |
|             |          | Select type of benefit for Services Supporting Self-Direction:                                   | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                                | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:   | 0.00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:  | Every month   |

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*EMR*

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                          | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Services Supporting Self-Direction?                            | No   |
|             |          | Notes:  | Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, continued education. |
|             |          | Does the plan provide General Supports for Living as a supplemental benefit under Part C? | Yes  |
|             |          | Select type of benefit for General Supports for Living:                                   | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount?                         | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?                          | No   |
|             |          | Is there an enrollee Coinsurance?   | No   |
|             |          | Is there an enrollee Deductible?  | No   |
|             |          | Is there an enrollee Copayment?   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for General Supports for Living?                                   | No   |

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**19b Additional Benefits for VBIID/UF/SSBCI - VBIID Package 1**

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category   | Question  | Response  |
|-------------|--|---|---|
| 19b - 13i   | Additional Benefits for VBIID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill | Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:<br><br>Enter name of Service:<br><br>Select type of benefit for Other 1:<br><br>Is there a service-specific Maximum Plan Benefit Coverage amount?<br><br>Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?<br><br>Is there an enrollee Coinsurance?<br><br>Is there an enrollee Deductible?<br><br>Is there an enrollee Copayment?<br><br>Is authorization required?<br><br>Is a referral required for Other 1 Services?<br><br>Notes:<br><br>Enter name of Service:<br><br>Select type of benefit for Other 2: | Other 1; Other 2; Other 3; Other 4<br><br>Home cleaning<br><br>Mandatory<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>No<br><br>Member may choose up to two (2) services per quarter (8 visits annually) of home cleaning, including preventive disinfection and yard clean-up, which is combined with pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling.<br><br>Pet care<br><br>Mandatory   |
|             |  |   | <p>Member may choose up to two (2) services per quarter (8 visits annually) for Home Assistance such as Plumbing repairs, Electrical repairs, Locksmith, and basic Technology Assistance. These are combined with pest control, home cleaning, pet grooming, and Hairstyling. The following additional items are covered through the VBIID Benefits Card: 1. Gasoline and auto repairs 2. Cleaning Products 3. Hardware/tools to support house maintenance/appliances 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, pen/pencil.</p> |
|             |  |   | <p>ADMINISTRACION DE<br/>SEGUROS DE SALUD</p> <p><b>№ 2 4 - 0 0 0 4</b></p> <p>Contrato Número <b>2412</b></p>  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response  |
|-------------|----------|---|---|
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0,00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 2 Services?                      | No  |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of pet grooming which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and Hairstyling. Pet food and supplies are covered by the VBID Benefits card. |
|             |          | Enter name of Service:  | Memory Fitness and Cognitive Function   |
|             |          | Select type of benefit for Other 3:                               | Mandatory   |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | Yes   |
|             |          | Indicate Maximum Plan Benefit Coverage amount:                    | 0,00  |
|             |          | Select Maximum Plan Benefit Coverage periodicity:                 | Every month   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No  |
|             |          | Is there an enrollee Coinsurance?                                 | No  |
|             |          | Is there an enrollee Deductible?                                  | No  |
|             |          | Is there an enrollee Copayment?                                   | No  |
|             |          | Is authorization required?  | No  |
|             |          | Is a referral required for Other 3 Services?                      | No  |

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

**Disease States:**

**Service Category Description**

**Benefit Description**

| PBP Section | Category | Question  | Response   |
|-------------|----------|---|--|
|             |          | Notes:  | Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card. |
|             |          | Enter name of Service:  | Hairstyling  |
|             |          | Select type of benefit for Other 4:                               | Mandatory  |
|             |          | Is there a service-specific Maximum Plan Benefit Coverage amount? | No   |
|             |          | Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  | No   |
|             |          | Is there an enrollee Coinsurance?                                 | No   |
|             |          | Is there an enrollee Deductible?                                  | No   |
|             |          | Is there an enrollee Copayment?                                   | No   |
|             |          | Is authorization required?  | No   |
|             |          | Is a referral required for Other 4 Services?                      | No   |
|             |          | Notes:  | Member may choose up to two (2) services per quarter (8 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.   |

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# Bid Reports 2024

## PBP Part D Benefits Report

MCS ADVANTAGE, INC.  
H5577 - 055  
VBID: Yes - Part C  
MA Uniformity Flexibility: No  
Special Supplemental Benefits for the Chronically Ill: No  
Part D Senior Savings Model: No

Region: New York  
Lead Marketing Region: New York  
Org. Marketing Name: MCS Classicare  
Plan Name: MCS Classicare Platino Del Sur (HMO D-SNP)  
Plan Geographic Name: Puerto Rico South 8  
Status: Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)

Plan Type: HMO  
Enrollee Type: Part A and Part B

Number of Tiers: N/A  
Part D Plan Premium: No  
Continuation Area Available: US - No  
Visitor/Travel Benefit Available: Yes, 00024446  
Formulary: Yes, Defined Standard  
Part D Benefit: Yes  
Special Needs Plan: Dual-Eligible  
Special Needs Plan Type: Medicare non-zero dollar cost sharing plan

Dual-Eligible SNP: Yes  
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? No

Standard Bid For Section B:

No



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Standard Bid For Section C:  
Standard Bid For Section D:

No  
No

| Part D Benefit Data  |  |
|--|--|
| Benefit  | Plan Data  |
| Deductible   | 545.00   |
| Pre-ICL Cost Shares  | 25%  |
| Initial Coverage Limit   | 5030.00  |
| Enrollee Out-of-Pocket Cost Threshold  |  |
| You pay for Over-the-Counter medications (OTCs) under the Utilization Management Program   | No   |
| Pharmacy Network Components  | Standard Retail; Out-of-Network; Standard Mail-Order; Long-Term Care |
| Notes Available  | No   |
| Sponsor attestation  | Sponsor attests that it will comply with 42 CFR 423.154.             |
| Indicate which tiers have insulin drugs (Select all that apply):                           |  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing one month supply:       | \$35.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing two month supply:       | \$70.00  |
| Indicate Insulin Copayment amount for Standard Retail Cost-Sharing three month supply:     | \$105.00   |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing one month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing two month supply:   |  |
| Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply: | \$105.00   |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy one month supply:            | \$35.00  |
| Indicate Insulin Copayment amount for Out-of-Network Pharmacy other day supply:            | \$35.00  |

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|   |   |
|---|---|
| Indicate Insulin Copayment Amount for Long Term Care Pharmacy one month supply: | \$35.00   |
| Vaccine Attestation:  | I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents. |
| Cost Shares Above the Threshold   |   |

| General Data  |           |
|---|-----------|
| Benefit   | Plan Data |
| All drugs on formulary available at extended days supply                                  | No        |
| Drugs available at an extended day supply limited to a 1-month supply for the first fill? | Yes       |
| Standard Retail Cost-sharing, 1 Month =   | 30 Days   |
| Standard Retail Cost-sharing, 2 Months =  | 60 Days   |
| Standard Retail Cost-sharing, 3 Months =  | 90 Days   |
| Out-of-Network Pharmacy, 1 Month =  | 30 Days   |
| Standard Mail Order Cost-Sharing, 3 Months =  | 90 Days   |
| Long Term Care Pharmacy, 1 Month =  | 31 Days   |

NOTE: See above for Defined Standard Cost Shares - Below the ICL and Cost Shares - Above the Threshold

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VBID - Part D Benefit Data

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



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**Bid Reports 2024**

**Plan Service Area Report**

MCS ADVANTAGE, INC.  
 H5377 - OS  
 VBI0: Yes - Part C  
 MA Uniformity Flexibility: No  
 Special Supplemental Benefits for the Chronically Ill: No  
 Part D Senior Savings Model: No

Region: New York  
 Lead Marketing Region: New York  
 Org. Marketing Name: MCS Classic  
 Plan Name: MCS Classic Planno Del Sur (HMO-D-SNP)  
 Plan Geographic Name: Puerto Rico South B  
 Status: Version 2 - Renewal - Successfully exported to desk review (05/06/23)

Plan Type: HMO  
 Enrollee Type: Part A and Part B  
 Part C Plan Premium: \$000  
 Part D Plan Premium: N/A  
 Continuation Area Available: No  
 Visitor/Travel Benefit Available: US - No  
 Formulary: Yes, D009446  
 Part D Benefit: Yes, Defined Standard  
 Special Needs Plan: Yes  
 Dual-Eligible SNP: Medicare non-zero dollar cost sharing plan  
 Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP? Yes

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

| State       | County       | County Code | Employer-Only County? | Pending County? | Partial County? |
|-------------|--------------|-------------|-----------------------|-----------------|-----------------|
| Puerto Rico | Cayno        | 40210       | No                    | No              | No              |
| Puerto Rico | Guayama      | 40290       | No                    | No              | No              |
| Puerto Rico | Juana Diaz   | 40370       | No                    | No              | No              |
| Puerto Rico | Penuelas     | 40550       | No                    | No              | No              |
| Puerto Rico | Perce        | 40560       | No                    | No              | No              |
| Puerto Rico | Sinas        | 40630       | No                    | No              | No              |
| Puerto Rico | Santa Isabel | 40670       | No                    | No              | No              |

**ADMINISTRACION DE  
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**Contrato Numero**

|             |         |       |    |    |    |                |
|-------------|---------|-------|----|----|----|----------------|
| Puerto Rico | Vitalba | 40750 | No | No | No | Zapachá: 00756 |
|-------------|---------|-------|----|----|----|----------------|

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**Contrato Número**

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# Bid Reports 2024

## Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.

H5577 - 055

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically Ill: No

Part D Senior Savings Model: No

Region:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Status:

Plan Type:

Enrollee Type:

Part C Plan Premium:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

Part D Benefit:

Special Needs Plan:

Special Needs Plan Type:

Dual-Eligible SNP:

Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Standard Bid For Section B:

New York  
New York

MCS Classicare

MCS Classicare Platino Del Sur (HMO D-SNP)

Puerto Rico South 8

Version 2 - Renewal - Successfully exported to desk review  
(06/06/23)

HMO

Part A and Part B

\$0.00

N/A

No

US - No

Yes, 00024446

Yes, Defined Standard

Yes

Dual-Eligible

Medicare non-zero dollar cost sharing plan

Yes

No

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Standard Bid For Section C:  
Standard Bid For Section D:

No  
No

| Plan Level Cost Shares and Limits   |                                      |
|---|--------------------------------------|
| Question  | Response                             |
| Is there an In-Network Plan Deductible?   | No                                   |
| 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 Lower, Intermediate or Mandatory Level?    | Lower                                |
| 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                                  |

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|  |  |
|--|--|
| Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount: | 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation Services; 3-4: SET for PAD Services; 4a: Emergency Services; 4b: Urgently Needed Services; 7a: Primary Care Physician Services; 7b: Chiropractic Services; 7c: Occupational Therapy Services; 7d: Physician Specialist Services; 7f: Podiatry Services; 7g: Other Health Care Professional; 7i: Physical Therapy and Speech-Language Pathology Services; 7j: Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-covered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Health Services |
|--|--|

|   |                 |
|---|-----------------|
| <b>Reductions in Cost Sharing - General</b> |                 |
| <b>Question</b>                             | <b>Response</b> |
| Do you offer Reductions in Cost Sharing?    | No              |

|   |                              |
|---|------------------------------|
| <b>Combined Benefits - General</b>  |                              |
| <b>Question</b>   | <b>Response</b>              |
| Do you offer Combined Supplemental Benefits?                                  | Yes                          |
| Select the number of Combined Supplemental Benefit packages you are offering? | 2                            |
| Combined Benefits Group 1 Name:   | Combined Eyewear and Hearing |




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|  |  |
|--|--|
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types) |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Combined Eyewear and Hearing Allowance   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | Yes  |
| Max Plan Benefit Amount:   | 500.00   |
| Select Maximum Plan Benefit Coverage Amount Periodicity:   | Every year   |
| Do you offer Combined Supplemental Benefits with a shared visit/trip limit?  | No   |
| Combined Benefits Group 2 Name:  | Combined Transportation  |
| Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:                           | 10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBI/D/UF/SSBCI                       |
| What is your combined supplemental benefits mode of delivery?  | Other  |
| Other Description:   | Transportation provided by contracted vendors.   |
| Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance? | No   |
| Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?   | No   |
| Do you offer Combined Supplemental Benefits with a shared visit limit?   | Yes  |
| Indicate number of shared visits:  | 12   |
| Select visit limit periodicity:  | Every year   |

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**WORKSHEET 6 - MA BID  
SUMMARY**

**I. General Information**

|                     |       |                       |  |                            |     |                  |  |
|---------------------|-------|-----------------------|--|----------------------------|-----|------------------|--|
| 1. Contract Number: | H5577 | 5. Organization Name: | MCS ADVANTAGE, INC.                        | 9. Enrollee Type:          | A/B | 13. Region Name: |  |
| 2. Plan ID:         | 055   | 6. Plan Name:         | MCS Classicare Platino Del Sur (HMO D-SNP) | 10. MA Region:             | N/A |                  |  |
| 3. Segment ID:      | 000   | 7. Plan Type:         | HMO  | 11. Act. Swap/Equiv Apply: | N   |                  |  |
| 4. Contract Year:   | 2024  | 8. MA-PD:             | Y  | 12. SNP:                   | Y   | 14. SNP Type:    |  |

**II. Other Information**

| A. Part B Information                         |          | B. Rebate Allocation for Part B  |          |
|---|----------|--|----------|
| 1. Maximum Pt B premium buydown amt., per CMS | \$164.90 | Premium  | \$150.00 |
|   |          | 1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)  |          |
|   |          | 2. Part B Rebate Allocation, rounded to one decimal (see instructions) | \$150.00 |

**ADMINISTRACION DE  
SEGUROS DE SALUD**  
№ 2 4 - 0 0 0 4

Contrato Número