### APPENDIX C (1)

Medicare Advantage Plan Benefit Package PBP



## Appendix C-I Plan Benefit Package (PBP) H5577 – 017

ADMINISTRACION DE SEGUROS DE SALUD I

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Contrato Número

EMR

## **Bid Reports 2024**

## **PBP** Benefits Report

VBID: Yes - Part C H5577 - 017 MCS ADVANTAGE, INC.

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically Ill: No

Part D Senior Savings Model: No

Visitor/Travel Benefit Available: Enrollee Type: Plan Type: Segment Geographic Name: Segment ID: Org. Marketing Name: Lead Marketing Region: Continuation Area Available: Part D Plan Premium: Part C Plan Premium: Status: Plan Geographic Name: Plan Name: \$0.00 Part A and Part B Version 3 - Renewal - Successfully exported to desk review (06/06/23) Puerto Rico MCS Classicare Platino Progreso (HMO D-SNP) MCS Classicare New York New York

Yes, 00024446

Medicare non-zero dollar cost sharing plan Dual-Eligible Yes, Defined Standard

Yes

8 8 8

Standard Bid For Section C: Standard Bid For Section B;

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

Dual-Eligible SNP: Special Needs Plan Type: Special Needs Plan: Part D Benefit: Formulary:

Standard Bid For Section D:

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

Contrato Número

Plan Level Data Response

JWZ.	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Colluate Winero	No	Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?
ď	Response	Question
	TO THE	Benefit Description
Nº 2 4 - 0 0 0 4		Service Category Description
SEGUROS DE SALUD		1b Inpatient Hospital-Psychiatric
ADMINISTRACION DE	Response	Question
1772	Common to the co	Benefit Description
		Service Category Description
Acceptance to the second secon		1a Inpatient Hospital-Acute
	Yes	Is a referral required for Inpatient Hospital-Acute Services?
	Yes	Is authorization required?
Williams II. Colored C	No	Do you charge cost sharing on the day of discharge?
	Original Medicare	What is your Inpatient Hospital-Acute benefit period?
	No	Is there an enrollee Copayment?
	No	Is there an enrollee Deductible?
7.00	No	Is there an enrollee Coinsurance?
Ad news	No	Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?
7.11.	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	No	Does the plan provide Inpatient Hospital-Acute Services as a supplemental benefit under Part C?
NO AND CASE A C. DES MARIE FORM. TO JUSTICATIONS.	Response	Question
The state of the s	177 00 00 00 00 00 00 00 00 00 00 00 00 0	Benefit Description
		Service Category Description
1200		1a Inpatient Hospital-Acute
	No	Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)
	Response	Question
	ces	Tiered Cost sharing for Part B Services

The season of the season company of the season of the seas	Question	TOTAL THE SECOND STATE OF			WHEN PRODUCT IN THE PROPERTY WITHOUT THE PROPERTY OF THE PROPE
And the state of t	Response	Benefit Description	Service Category Description	1b Inpatient Hospital-Psychiatric	1.6. Administrative desires reserve construction American desires construction American desires construction and american construction and american desires construction and american desires and amer
		Transfer tra			

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	ADMINISTRACION DE
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero	SEGUROS DE SALUD
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	超24-0004
Is there an enrollee Coinsurance?	No	Contrate Nikmara
Is there an enrollee Copayment?	No	Contrato tanneto
What is your SNF benefit period?	Original Medicare	
		0 2 2

	2 Chilled Ninging Escility (GNE)	) Skillad
	Yes	Is a referral required for SNF Services?
1/201	Yes	Is authorization required?
111/2	No	Do you charge cost sharing on the day of discharge?
1	Response	Question
	Benefit Description	Be
2	Service Category Description	Service
	2 Skilled Nursing Facility (SNF)	2 Skilled

ADMINISTRACION DE SEGUROS DE SALTID	\$0.00	Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation \$0.00
	\$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 Cardiac Rehabilitation Services:
	No	Is there an enrollee Copayment?
	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	No .	Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?
and desired	Response	Question
	and the same of th	Benefit Description
		Service Category Description
	ervices	3 Cardiac and Pulmonary Rehabilitation Services
And Andrew Application of the Control of the Contro	Response	Question
The state of the s	And the same and a state of th	Benefit Description
		Service Category Description
		2 Skilled Nursing Facility (SNF)

Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:

\$0.00

Contrato Número

\$0.00

\$0.00

 $Indicate \ Minimum \ Copayment \ amount \ per \ service \ for \ Medicare-covered \ Pulmonary \ Rehabilitation \ Services:$ 

Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:

3 Cardiac and Pulmonary Rehabilitation Services	n Services
Service Category 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
The second section of the second section of the second section of the second section of the second section sec	

3 Cardiac and I	3 Cardiac and Pulmonary Rehabilitation Services
Servi	Service Category Description
	Benefit Description
Question	
4a	4a Emergency Services
Servi	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 comment of the com
Is there an enrollee Copayment?	No

	Response	Question
Contrato Numero	Benefit Description	
Contents	Service Category Description	
m24-0004	4b Urgently Needed Services	
	Response	Question
SEGUROS DE SALLID	Benefit Description	The state of the s
ADMINISTRACIONA	Service Category Description	
	4a Emergency Services	

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Service Category Description	
Benefit Description	
Question	Response
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	erage
Service Category Description	
Benefit Description	
Question	Response
loes 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 SECTION DE CALLING
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No 0 2 4 - 0 0 1
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 Contrato Numero
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.

5 Partial Hospitalization	
Service Category Description	
Benefit Description	)
Question	Response
illee 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
	No
The second of th	the state of the s

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

Contrato Número	No o	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
# Z 4 = U U U 4	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Response	Question
SEGUROS DE SALUD	1	Benefit Description
ADMINISTRACION DE	on	Service Category Description
	vices	7a Primary Care Physician Services

	7b Chiropractic Services		
	Service Category Description		
-	Benefit Description		
	Question	Response	)
	Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes	X
	Select enhanced benefit:	Routine Care	1
	Select type of benefit for Routine Care:	Mandatory	1
	Is this benefit unlimited for Routine Care?	No, indicate number	-
	Indicate number of visits for Routine Care:	6	
	Select Routine Care periodicity:	Every year	
-	Were a service-specific Maximum Plan Benefit Coverage amount?	No	
1	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
	Is there an enrollee Coinsurance?	No	
	Is there an enrollee Copayment?	No	
6	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	
		· martines con	

7c Occupational Therapy Services	Therapy Services	
Service Category Description	ory Description	
Question Benefit Do	Benefit Description  Response	Total Indiana
Out-of-Pocket Cost?	and the second s	
Is there an enrollee Coinsurance?	No	ADMINISTRACION DE
Is there an enrollee Deductible?	No	OLUGINOS
Is there an enrollee Copayment?	No	W 2 4 - 0 0 0 4
Is authorization required?	Yes	11-12-1-0-0-0
Is a referral required for Occupational Therapy Services?	No	
		Oranin Ni Oteatuo

Service Cated	Service Category Description	
Benefit I	Benefit Description	
	Response	//
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
Is there an enrollee Coinsurance?	No	X
Is there an enrollee Deductible?	No	2
Is there an enrollee Copayment?	No	
Is authorization required?	No	- /
Is a referral required for Physician Specialist Services?	Yes	
the transfer and the control of the	THE REPORT OF THE PROPERTY OF	

7e Mental Health Specialty Services	ty Services
Service Category Description	cription
Benefit Description	on .
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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Service Category Description 7f Podiatry Services

Benefit Description

Response

Question

7f Podiatry Services	es	
Service Category Description	cription	
Benefit Description	On	
Question	Response	Administration and the second
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	
4 a referral required for Podiatrist Services?	Yes	
7g Other Health Care Professional Services	ional Services	
Service Category Description	cription	
Benefit Description	<b>On</b>	
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	AD AINISTRACION DB
Is there an enrollee Coinsurance?	No	STATE OF STA
Is there an enrollee Deductible?	No	~
Is there an enrollee Copayment?	No	11-24-0004
Is authorization required?	No	
Is a referral required for Other Health Care Professional Services?	Yes	Contrato Número

7h Psychiatric Services	
Service Category Description	
Benefit Description	S
ion	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
e;	No
Is there an enrollee Deductible?	

7h Psychiatric Services	vices	
Service Category Description	scription	
Benefit Description	tion	
	Response	The state of the s
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	3/
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	\$0.00	C. CORP. C.
Is authorization required?	No	- (BE)
Is a referral required for Psychiatric Services?	No	•
The state of the s		

7i Physical Therapy and Speech-Language Pathology Services	Pathology Services	
Service Category Description	ition	-
Benefit Description	5	Transit Inc.
Question	Response	to province of the designation of the second
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	ADMINISTRACION DE
Is there an enrollee Deductible?	No	SEGURUS DE SALOD
Is there an enrollee Copayment?	No	MO 0 - 0 0 0 4
?	Yes	11 11 11 11 11 11 11 11 11 11 11 11 11
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No	

7 Additional Telehealth Benefits	ts Contrato Numero
Service Category Description	
Benefit Description	Car
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

7j Additional Telehealth Benefits	S
Service Category Description	
Benefit Description	
	. O
Is there an enrollee Coinsurance?	11
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	ices
Service Category Description	
Benefit Description	
Question	Response
vice-specific Maximum 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	nd Lab Services	
Service Category Description		
Benefit Description		A mass
Question	Response	
ıt-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	NO ADMINISTRACION DE	CION DE
Is there an enrollee Copayment?	No SEGUROS DE SALUD	E SALUD
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	004
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	\$0.00	

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	logical Services	8b Outpatient Diagnostic and Therapeutic Radiological Services
- Named of Charac	Yes	Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?
اند	Yes	Is authorization required?
	No	If a member receives multiple services at the same location on the same day, does only the maximum copay apply?
	\$0.00	payn
7	Response	Question
	TOTAL CARE	Benefit Description
		Service Category Description
	d Lab Services	8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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	is.
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:	\$0,000
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
Pudicate 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
Ent. 13.	MACANA, I

Question			
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	5-8-1 min		
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	Bene	Service Ca	9a Outpatie
	Benefit Description	Service Category Description	9a Outpatient Hospital Services
Response	The same and the s	ption	rvices
quantification class to the control Act 2 of	1		
	4 5 74		

9b Ambulatory Surgical Center (ASC) Services	er (ASC) Services	
Service Category Description	scription	
Benefit Description	tion	AND THE REAL PROPERTY AND THE PROPERTY A
	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	ADMINISTRACION DE
Is there an enrollee Deductible?	No	SEGONOS DE SALOD
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	rvices
Service Category Description	n
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	state of the second sec
Service Category Description	3
Question	Response
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	
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

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Is a referral required for Outpatient Blood Services?

Is authorization required? Is there an enrollee Copayment?

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10a Ambulance Services Service Category Description	ion	
Benefit Description		THE PERSON NAMED IN COLUMN TO SERVICE STATE OF SERVICE STATE STATE STATE OF SERVICE STATE STA
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	1
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	ref. at a
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	\$0.00	9
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:		
Is authorization required for non-emergency Medicare services?	Yes	-
	***	
10h Transportation Convices	Do	

## 10b Transportation Services

## Service Category Description

### Benefit Description

Benefit Description	manuscripts.
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 ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No Nº 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No

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10b Transportation Services	
Service Category Description	
	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 HRNs, and 13i4 - Transportation for Non-Medical Needs.

Service Category Description  Benefit Description	cription on
Question	Response
there a service-specific Maximum 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	D.G.
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 ADMINISTRACION DE
Is there an enrollee Copayment?	No SEGURUS DE SALUD
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

Notes: Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.	Is authorization required?	Question	Benefit Description	Service Category Description	11b Prosthetics/Medical Supplies
es) is managed				,	

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or	eutic Shoes or Inserts
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
k mere 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	
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
	No
Is a referral required for Dialysis Services?	No

13a Acupuncture	
Service Category Description	ption
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

ADMINISTRACION DE SEGUROS DE SALUD

Contrato Número MR 19/42

e-Counter		trans.		3 1	Ampleon for elegation on a			
(OTC) Items as a supplemental benefit under Part C?	**************************************	Benefit Description	Service Category Descrip	13b Over-the-Counter (OTC	a description of the state of t	Benefit Description	Service Category Descrip	13a Acupuncture
No	Response		tion	) Items	Response	2	tion	
	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?	<b>Respon</b> No	Respon	on Respon	TC) Items ription n Response	Response TC) Items ription n Response	Response TC) Items ription n Response	ription  Response  TC) Items  ription  n  Response

Question	The same of the sa			Does the plan provide a limited duration Mea Only primarily health-related meals offered in entered in this section.	Question			
	Benefit Description	Service Category Description	13d Other 1	Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.		Benefit Description	Service Category Description	13c Meal Benefit
Response	A CONTRACTOR OF THE PROPERTY O	on	200 / 1	No	Response		on	

13e Other 2

**Service Category Description** 

**Benefit Description** 

Response

Question

SEGUROS DE SALUD

12 2 4 - 0 0 0 4 EMR

Question				Question	Park from Processing ( , , eg , , , ,		;	Question			
Response	Benefit Description	Service Category Description	13i Non-Primarily Health Related Benefits for the Chronically II	Response	Benefit Description	Service Category Description	13g Dual Eligible SNPs with Highly Integrated Services	Response	Benefit Description	Service Category Description	13f Other 3
		scription	efits for the Chronically III	Response		scription	Integrated Services	Response	tion	scription	

14a Medicare-covered Zero Cost-Sharing Preventive Service	ventive Services
Service Category Description	3
Ве	
Question	Response
-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** Response

Question

ADMINISTRACION DE SEGUROS DE SALUD

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

140 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 ADIMINIST RACION DE SEGUROS DE SALUD
Is this benefit unlimited?	No
Indicate limit for number of sessions	6 24-0004
Indicate the number of sessions periodicity:	Every year

14c Other Defined Supplemental Benefits	nefits
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 ADMINISTRACION DB
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	\$0.00 SEGUKUS DE SALUD
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 Contrato Número
Indicate Maximum Copayment amount for Alternative Therapies:	\$0.00
Is authorization required?	No Y
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.

14d Kidney Disease Education Services	vices
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 rejerral required for Kidney Disease Education Services?	No
14e Other Medicare-Covered Preventive Services	e Services
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0,00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0,00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0.00 ADMINISTRACION DB
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	\$0.000 SECONOS DE SALUD
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:	\$0,000 Contrato Número
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 YEAR

14e Other Medicare-Covered Preventive Services	tive Services
Service Category Description	ion
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
	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs	ision 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

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004 EMR Contrato Número

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

Question	kesponse
Does the plan provide Preventive Dental Items as a supplemental benefit under Part C?	No
16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, P Surgery, Other Services)	Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial )ther 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 ADMINISTRACION DE
Is this benefit unlimited for Periodontics?	Yes SEGUROS DE SALUD
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 Contrato Número

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:	Еvery year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is more an enrollee Coinsurance?	No
s 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 SEGUROS DE SALLID
Is a referral required for Comprehensive Dental Services?	No

		Mandatory	Select type of benefit for Eyeglasses (lenses and frames):
		Yes	Is this benefit unlimited for Contact lenses?
	-	Mandatory	Select type of benefit for Contact lenses:
	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames	Contact lenses; Eyeglass Eyeglass frames	Select enhanced benefits:
		Yes	Does the plan provide Eyewear as a supplemental benefit under Part C?
		Response	Question
	CMIC		Benefit Description
	0 0		Service Category Description
		and the second of the second s	17b Eyewear
	Contrato Numero	No	Is a referral required for Eye Exams?
	( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	No	Is authorization required?
	<b>10004</b>	No	Is there an enrollee Deductible?
		\$0.00	Indicate Maximum Copayment amount for Routine Eye Exams:
1	SEGUROS DE SALITA	\$0.00	Indicate Minimum Copayment amount for Routine Eye Exams:
	ADMINISTRACION DE	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
•		\$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:
		No	Is there an enrollee Copayment?
		No	Is there an enrollee Coinsurance?
	4	No	Mere a service-specific Maximum Enrollee Out-of-Pocket Cost?
100		No	Is there a service-specific Maximum Plan Benefit Coverage amount?
1		Every year	Select the Routine Eye Exams periodicity:
\	Less .	1	Indicate number of exams for Routine Eye Exams:
		No, indicate number	Is this benefit unlimited for Routine Eye Exams?
1		Mandatory	Select type of benefit for Routine Eye Exams:
J		Routine Eye Exams	Select enhanced benefit:
		Yes	Does the plan provide Eye Exams as a supplemental benefit under Part C?
7		Response	Question
			Benefit Description
			Service Category Description
			17a Eye Exams

efit maximum amount includes repair of eyewear. or member must verify remaining combined maximum coverage amount available.	Eyewear benefit maximum amount includes repair of eyewear. Provider and/or member must verify remaining combined maxiplan benefit coverage amount available.	Notes:
	No	Is a referral required for Eyewear?
Contrato Número	No	Is authorization required?
, , , , , , , , , , , , , , , , , , ,	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
1	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:
24-000	No	Is there an enrollee Copayment?
OF GOVERNMENT OF STREET	No	Is there an enrollee Deductible?
SECTION SECTION DE	No	Is there an enrollee Coinsurance?
A TOTAL TEXT TO THE TAX TO THE TA	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Every year	Select the Combined Maximum Plan Benefit Coverage periodicity:
and Alex	1000.00	Indurate Combined Maximum Plan Benefit Coverage amount:
	Yes	Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?
	Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
	Yes	Is this benefit unlimited for Eyeglass frames?
	Mandatory	Select type of benefit for Eyeglass frames:
121	Yes	Is this benefit unlimited for Eyeglass lenses?
	Mandatory	Select type of benefit for Eyeglass lenses:
	Yes	Is this benefit unlimited for Eyeglasses (lenses and frames)?
	Response	Question
1 1	to in the strain don	Benefit Description
		Service Category Description
		17b Eyewear

18a Hearing Exams	15
Service Category Description	ription
Benefit Description	SN .
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 a referral required for Hearing Exams? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there an enrollee Deductible? Select Fitting/Evaluation for Hearing Aid periodicity: Is this benefit unlimited for Fitting/Evaluation for Hearing Aid? Select type of benefit for Fitting/Evaluation for Hearing Aid: Select Routine Hearing Exams periodicity: Is authorization required? Indicate Maximum Copayment amount for Medicare-covered Benefits: Is there an enrollee Copayment? Is there an enrollee Coinsurance? Is there a service-specific Maximum Plan Benefit Coverage amount? Is this benefit unlimited for Routine Hearing Exams? Question Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid: Indicate Maximum Copayment amount for Routine Hearing Exams Indicate Minimum Copayment amount for Routine Hearing Exams: Indicate Minimum Copayment amount for Medicare-covered Benefits: Indicate number for Fitting/Evaluation for Hearing Aid: Indicate number for Routine Hearing Exams: Service Category Description 18a Hearing Exams **Benefit Description** \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 No S 8 No 8 8 No, indicate number Mandatory Every year No, indicate number Š Every year Response ADMINISTRACION DE SEGUROS DE SALUD 124-0004 Contrato Número

Question  Benefit Description  Question  Does the plan provide Hearing Aids as a supplemental benefit under Part C?  Select enhanced benefits:  Select type of benefit for Hearing Aids (all types):	Response Yes Hearing Aids (all types) Mandatory
18b Hearing Aids	
Service Category Description	
Benefit Description	
THE THE PARTY OF T	Response
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	
	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory

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18b Hearing Aids	
Service Category Description	on
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
Indiselve Maximum Plan Benefit Coverage periodicity:	Еvery year
s mere 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.

Question  20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs  Service Category Description  Benefit Description  Response  ADMINISTRACION DE SEGUROS DE SALUD  Benefit Description		Response	Question
Response  20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs  Service Category Description	1000	Benefit Description	\$ P
Response  20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	SEGUROS DE SALUD	Service Category Description	
Response	ADMINISTRACION DE	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	
Response			
			Question

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

Contrato Número

EMR 31/42

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

Question	Response	5
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No	11
Low Many, professor do your Additional Banefite contains (1-15)	Ford	

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

### Service Category Description Disease States:

West and the Comment of the Comment	Benefit Description	man and a second
tegory	Question	Response
ditional Benefits for ID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
THE PROPERTY OF STREET, STREET, ST.		

PBP Section	Category	Question	Response
196	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
	of the state of th	Targeting Methodology - Please choose one or both:	Socioeconomic Status
No.		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	26650
		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:	13i10: General Supports for Living; 13i1: 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 ADMINISTRACION DE

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

### Disease States:

## Service Category Description

### Benefit Description

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PBP Section	Category	Question	Response
100 100 100 100 100 100 100 100 100 100		Notes:	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.
196 - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically III 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
1		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
3		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:	80.00
		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:	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 ADMINISTRACION DE
		Select type of benefit for Pest Control:	Mandatory SEGUROS DE SALUD

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## Disease States:

# Service Category Description

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											1000							Category	- Contract of the Contract of
Is this benefit unlimited for number of trips for Any Location?	Description:	Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	Select Plan-approved Location Trips periodicity:	Indicate number of trips for Plan-approved Location:	Is this benefit unlimited for number of trips for Planapproved Location?	Select type of benefit for Plan-approved Location:	Select enhanced benefit:	Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Notes:	Is a referral required for Pest Control?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Question	Benefit Description
No	Fleet includes sedans, minivans, buses with hydraulic ramps.	Van; Medical Transport	One-way Contrato Número	Every year	0 24-0004	No SEGUROS DE SALUD	Mandatory ADMINISTRACIO DE	Plan-approved Location	Yes	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.	No	No	No	No	No	No	No	Response	- data will prime the

### Disease States:

## Service Category Description

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											No.		7		7 400					PBP Section	
															2		# 1			Category	And a second sec
Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Indoor Air Quality Equipment and Services:	Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Notes:	Is a referral required for Transportation for Non-Medical Needs?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Description:	Select Mode of Transportation for Non-Medical Needs for Any Location:	Select Type of Transportation for Non-Medical Needs for Any Location:	Select Any Location Trips periodicity:	Indicate number of trips for Any Location:	Question	Benefit Description
No	№ 2 4 - 0 0 0 A	Every month	0.00 SECTION DB	Yes	Mandatory	Yes	Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.	No	No	No	No	No	No	No	Fleet includes sedans, minivans, buses with hydraulic ramps.	Van; Medical Transport	One-way	Every year	0	Response	Communities with Contraction Contraction

### Disease States:

## Service Category Description

## Benefit Description

		Delle It Described	
PBP Section	Category	Question	Response
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
S S S S S S S S S S S S S S S S S S S		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
T		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 No Cost?	No
		Is there an enrollee Coinsurance?	No
L.		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

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

Contrato Número

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## Disease States:

# Service Category Description

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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.
1		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
1		Indicate Maximum Plan Benefit Coverage amount:	0.00 ADMINISTRACION DE
		Select Maximum Plan Benefit Coverage periodicity:	Every month SEGUROS DE SALUD
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No №24-0004
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No Contrato Vimero
	Average of the second	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 prebiotic or probiotic products are also commonly used (NCCIM, 2016a).

### **PBP Section** Category Does the plan provide Services Supporting Self-Direction as Yes a supplemental benefit under Part C? Is there a service-specific Maximum Plan Benefit Coverage amount? Select type of benefit for Services Supporting Self-Is there an enrollee Copayment? Is there a service-specific Maximum Enrollee Out-of-Pocket No Is there a service-specific Maximum Plan Benefit Coverage Select type of benefit for General Supports for Living: Does the plan provide General Supports for Living as a supplemental benefit under Part $\mathbb{C}$ ? Is a referral required for Services Supporting Self-Direction? Is there an enrollee Deductible? Is there an enrollee Coinsurance? Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost? Select Maximum Plan Benefit Coverage periodicity: Indicate Maximum Plan Benefit Coverage amount: Question Is there an enrollee Coinsurance? amount? Is authorization required? Is there an enrollee Copayment? Is there an enrollee Deductible? 19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Service Category Description **Benefit Description** Disease States: Yes 0.00 8 Services supporting self-direction are covered through the VBID Benefits Card and include classes in technology, language, financial and other types of supporting courses, 8 S. 8 Yes 8 8 8 S 8 Every month Mandatory continued education. Mandatory Response ADMINISTRACION DE 1024-0004 SEGUROS DE SALUD Contrato Número

SWR

### Disease States:

# Service Category Description

		1								19b - 13i				PBP Section C
			appris.						A STATE OF THE STA	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III				Category
Notes:	Is a referral required for Other 1 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 1:	Enter name of Service:	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Notes:	Is a referral required for General Supports for Living?	Is authorization required?	Question
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.	No	No	No Contrato Número	No	No 24-0004	No SEGURUS DE SALUD	ADMINISTRACION DE	Mandatory	Home cleaning	Other 1; Other 2; Other 3; Other 4	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.	No	No	Response

## Disease States:

# Service Category Description

													A STATE OF THE STA							P		<b>PBP Section</b>	The second secon
															2	The state of the s						Category	
Is a referral required for Other 3 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 3:	Enter name of Service:	Notes:	Is a referral required for Other 2 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 2:	Question	Benefit Description
No	No 10 2 4 - 0 0 0 4	No	No SEGUROS DE SALUD	NO APPRIMINATE VOIDE DE	No	Every month	0.00	Yes	Mandatory	Memory Fitness and Cognitive Function	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.	No	No	No	No	No	No	Every month	0.00	Yes	Mandatory	Response	

### Disease States:

## Service Category Description

## **Benefit Description**

The second secon	The state of the s	The state of the s	And the state of t
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 No Cost?	No
A STATE OF THE PARTY OF THE PAR		Is there an enrollee Coinsurance?	No
8		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.

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

### **Bid Reports 2024**

### **PBP 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

ADMINISTRACION DE SEGUROS DE SALUD

№24-000 4

Contrato Número

Region:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Status:

Plan Type:

Enrollee Type:

Number of Tiers:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Part D Benefit:

Formulary:

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 Progreso (HMO D-SNP)

Puerto Rico

Version 3 - 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

6.4 I

Medicare non-zero dollar cost sharing plan Yes

: No : No

Part D Be	enefit 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	No
Utilization Management Program	
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):	
	ADMINISTRACION DE
Indicate Insulin Copayment amount for Standard Retail Cost-	
Sharing one month supply:	SECRES DE SALOD
Indicate Insulin Copayment amount for Standard Retail Cost-	\$70.00
Sharing two month supply:	№ Z 4 - U U U 4
Indicate Insulin Copayment amount for Standard Retail Cost-	\$105.00
Sharing three month supply:	Contrata Namara
Indicate Insulin Copayment amount for Standard Mail Order	Somuto (valieto
Cost-Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Mail Order	S W//
Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order	\$105.00
Cost-Sharing three month supply:	
Indicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care	\$35.00
Pharmacy one month supply:	
Vaccine Attestation:	I attest that there is no deductible and no cost sharing for an
	adult vaccine recommended by the Advisory Committee on
	Immunization Practices (ACIP). There is no enrollee cost
	sharing on the ingredient cost of the vaccine submitted on
	the prescription drug event (PDE) record, or any associated
	sales tax, dispensing fee, or vaccine administration fee,
	regardless of tier placement or benefit phase. The applicable
	vaccines will be designated as such on the beneficiary-facing
	formulary model documents.
Cost Shares Above the Threshold	

Gen	eral 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-	Yes
month supply for the first fill?	
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 I	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 SEGUROS DE SALUD

 $N^{\circ} 24 - 0004$ 

Contrato Número

EMR

### Bid Reports 2024

### Plan Service Area Report

MCS ADVANTAGE, INC. HS577 - 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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Putto Ricc Basiene Paulno Pregress (HMO D-549)
Putto Ricches (PG/PG/23)
Putt A und Paut B
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NA
NA
NO
NO
NO
Yes, DOZIANE
Yes, DOZIANE
Yes, DOZIANE Rogibn: Lead Marketing Region: Org. Marketing Name: Plan Name: Plan Geographic Name: Status:

Plan Type:
Enrollee Type:
Part C Plan Perenlium:
Part D Plan Perenlium:
Continuation Area Available:
Visitor/Travel Benefit Available:

Formulary:
Part Bermulary:
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Special Needs Plan:
Special Needs Plan:
Special Needs Plan:
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Ves Dual-Eligible Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE SEGUROS DE SALUD M24-0004 Contrato Número

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerlo Rico	Adjuntas	70010	NO	O Z	No Zipcode(s): 00601
rto Rico	Aguada	00007	No	No	No Zipcode(s): 00602
Puerto Rico	Aguadiila	40030	No	No	No Zipcodn(s): 00603; 00604; 00605; 00690
Puerto Rico	Aguas Buenas	40040	ND	No	No Zpcode(s): 00703
Puerto Rico	Aibonito	40050	No	No	(No Z pcode(s): 00705; 00786
Puerto Rico	Ainsco	40060	Na	No	No Zipcodu(s): 00610; 00670
Puerto Rico	Arecibo	40070	No	<u> </u>	No Zipcode(s): 006.12; 006.13; 006.14; 005.16; 00652; 00688
Pucrto Rico	Arroyo	40080	NO	N O	No Zipcodajsj: 00714
Puerto Rico	Barceloneta	40090	No	N.	No Zijicode(s): 00617
Puerto Rico	Barranquitas	40100	No	Q.	No Zipcode(s): 00799
Puerto Rico	Вауатоп	40110	lła	No	Na 2 prode(s): 0/934; 00/956; 00/957; 00/958; 00/959; 00/960; 0/9961
Pινεπα Rico	Cabo Rujo	40120	Nα	N O	No Zipitoda(s): 00622; 00633
Ривто Лісо	Caguas	AD13G	No	N.	No Z)pcode(s); 00725, 00726; 00727

Puerto Rica	Сатиу	40140	No	No	No Ziscodelel: 00637: 00630
Puerto Rico	Canovanas	401.45	Мо	No	No
		Ansen			Zipcode(s): 00729; 00745
Puerto Rico	Carolina				Zipcode(3): 00979; 0/1981; 0/0982; 0/0983; 0/0984; 0/0985; 0/0988; 0/0988; 0/0988; 0/0988;
Puerto Rico	Catano	40160	No	No	ИО
Puerto Rico (	Cayey	40170	No	Νο	Zipcode(s): 00962; 00963 No
					Zipcode(s): 00736; 00737
Puerto Rico	Coiba	40180	Ма	No	No Z.pcode(s): 00735; 00742
Puerta Rico	Gales	40190	ય૦	No	(4a) Zinconiele): 00638
Puerto Rico	Crdra	40200	Мо	Na	Roomstary, 2003.0
Pucrto Rico	Соять	40210	No	No	No
Puerto Rica	Comeria	40220	No	No	No Thorotalisty 10782
Puerto Rico	Corozal	40230	No	No	No Zipcode(s): 00783
Puerto Rico	Сиювт	96240	Ио	No	No Zipcode(s): <b>007</b> 75
Puerto Rica	Dorado		No	No	No Zpcvade(s): 00646
	Fajardo	40260	Ио	Мо	No Zipcode(s): 00738; 00740
Puerta Rica	Florida	4026,5	Мо	No	No Zipcodels): 00650
Puerto Rico	Guanica	40270	Ма		lka Zipcodels): 00647; 00653
	Guayama	402RD	No		No Zipcode(s): 00764; 00784; 00785
	Guayanilla	40290	No		l/o Zipcode(s): 00656; 00785
Puerto Rico	Guaynabo	40300	Мо	Мо	No Zipcode(s): 00934; 00965; 00966; 00968; 00968; 00970; 00971
	Gurabo	40310	No		No Zijicode[s]: 00778
	Hatillo	40370	No		ldo. Zijnanda[si: 00659
	Hormigueros	40330	140		No Zijicodels): 00660
	Нипасар	40340	No		No Zipcade(s): 60741; 00745; 0/791; 0/792
Puerto Rico	Sabela	10350	Мо	No	No Zipcodeisj: 00662
	eknkej	10360	Чо	No	No Librade(s): 00664
Рие по Rico	Juana Diaz	40370	No	No	ADMINISTRACION DE
		1			SEGUROS DE SALUD

Puerro Rico         Loncos           Puerro Rico         Lants           Puerro Rico         Lants           Puerro Rico         Las Marias           Puerro Rico         Las Piedras           Puerro Rico         Las Piedras	40380	. d	No No	No No	No Zipcodu(s): 00777 No
	4039	OF		No	No
					Zivrode(c) 00662
	40400	01	No	NO.	Zipcote(s): 00631: 00669
	A0410	01	NO.	No.	No Zipcode(s): 00670
	48420	0.5	No	CN	No Zipcode(s): 00771
	40430	30	No	No	No Zincode(s): 00772
Puerto Rico Luquillo	40440	40	Na	No	No Zincrite(\$): 00273
Puerto Rico Manati	40450	05	No	No	No Zilezdelek, Ontzia
Puerto Rico Marleno	40460	05	No	QN.	No Zwcode(s): 00606
Mannabo	40470	70	Na	ND	No Zincode(t): 017.97
Puerto Rico Maynguez	40480	80	No	No	Na 2(mcadels): 00680; 00681; 00682
Puerto Rico Moca	1049D	06	No	NO.	Na Zipcode(s): 006/6
Puerto Rico Marovis	40500	00	No	No	No Zipcode(s): 00587
Puerto Rico Naguabo	40510	10	No	No	(40) Zipcode(s): 00718; t0744
Puerto Rico Naranjito	40520	50	140	No	No   Zincodels): (307.19
Puerto Rico Oraconis	40530	30	No	No	No Zincode(s): 0DZ20
Puerto Rico Patillas	40540	40	No	No	No Zipodels): 00723
Puorta Rico Penuelas	40550	05		No	Ma Zipcade(s): 00624
Puerto Rico Ponce	40560	09	No	NO.	No 75ccae(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732; 00733, 00734; 00780
Puerta Rico (Quebradillas	40570	70	No	O <sub>N</sub>	No Zincode(s): 00678
Puerto Rico	40580	08	No	No	No Zijucode(s); 00627
Puerto Rico Rio Grande	40590	06	No	No	Mn Zijicode(s): 00721; 00745
Puerto Rico Sabana Grande	40610	10	No	No	No Zpcode(s): 00637
Puerto Rico Salinas	40620	20	ON	NO	No Zipcode (s): 00704; 00751
Puerto Rico San German	40630	30	N	No	No Zincotels: 00635: 00683
					SECTIFICE DE SALID

EMR #24-0004

# ADMINISTRACION DE SEGUROS DE SALUD

Zipscade (s): 00902; 00905; 00906; 00300; 00300; 00300; 00300; 00310; 00315; 00315; 00315; 00315; 00315; 00315; 00315; 00315; 00315; 00315; 00325; 00

Zipcode(s): 00754 No Zipcade(s): 00685 No Zipcode(s): 00757 No

40650

40670

San Sebastian anta Isabel

San Juan

Puerto Rico

Zipcode(s): 00949; 00950; 00951; 00952 Zipcode(s): 00976; 00977; 00978

Zipcodels): 00611; 00641 Zipcade(s): 00692; 00694 Zipcode(s): 00693; 00694

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verto Rico verto Rico 40760

Yabucna

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Zipcode(s): 00765 Zipcode(s): 00765 Zipcode(s): 00767 Zipcodels): 00698

Zipcade(s): 00953; 00954 No

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### **Bid Reports 2024**

### **Plan Level Cost Shares and Limits 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:

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:

Contrato Número

New York New York

MCS Classicare

MCS Classicare Platino Progreso (HMO D-SNP)

Puerto Rico

Version 3 - Renewal - Successfully exported to desk review

(06/06/23)

НМО

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

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

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

Plan Level Cost S	Shares and Limits
Question	Response
Is there an In-Network Plan Deductible?	No
Is there an In-Network Maximum Enrollee Out-of-Pocket	Yes
Cost?	
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP)	Lower
Cost at the Lower, Intermediate or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00
Amount:	-
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits
Enrollee Out-of-Pocket cost:	

EMR №24-0004

Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes Contrato Número
apply to all In-Network Medicare-covered plan services?	
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 Co	ost Sharing - General
Question	Response
Do you offer Reductions in Cost Sharing?	No

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

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

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

Contrato Número

EMR

De

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

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

II. Other Information		
A. Part B Information	B. Rebate Allocation for Part B Premium	
	1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)	
1. Maximum Pt B premium buydown amt., per		
CMS \$164	\$164.90   2. Part B Rebate Allocation, rounded to one decimal (see instructions)	

ADMINISTRACION DE SEGUROS DE SALUD

N24-000 4



# Appendix C-I Plan Benefit Package (PBP) H5577 – 029

ADMINISTRACION DE SEGUROS DE SALUD

Nº 2 4 - 0 0 0 4

Contrato Número

EMR

## **Bid Reports 2024**

## **PBP Benefits Report**

VBID: Yes - Part C H5577 - 029 MCS ADVANTAGE, INC.

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

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

Part C Plan Premium: Part D Plan Premium: Emrotee Type:

Continuation Area Available:

Visitor/Travel Benefit Available:

Part D Benefit: Formulary:

Special Needs Plan Type:

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

Dual-Eligible SNP: Special Needs Plan:

Standard Bid For Section B:

Standard Bid For Section D: Standard Bid For Section C:

Question

New York

New York

MCS Classicare

MCS Classicare Platino MasCa\$h (HMO D-SNP)

Puerto Rico

Part A and Part B

N/A \$0.00 8

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

8 8 8

Plan Level Data

Response

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

№24-0004

ADMINISTRACION DB SEGUROS DE SALUD,

Tiered Cost sharing for Part B Services	Ses
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	I'val
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
Were an enrollee Coinsurance?	No
14 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

Response  ADMINISTRACION DE SEGUROS DE SALUD  Service Category Description  Benefit Description  Benefit Description  Response  Contrato Número  hiatric Services as a supplemental benefit under Part C?  No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
1b Inpatient Hospital-Psychiatric  Service Category Description  Benefit Description  Response	Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?
1b Inpatient Hospital-Psychiatric Service Category Description  Benefit Description	e data e e mais e mais de mais
1b Inpatient Hospital-Psychiatric  Service Category Description	Benefit Description
1b Inpatient Hospital-Psychiatric	Service Category Descr
Benefit Description Response	1b Inpatient Hospital-Psy
Response ADMINIS	And the second control of the second control
BENEfit Description	A CONTRACTOR OF THE CONTRACTOR
J	Complete to the control of the contr
Service Category Description	Service Category Descr

1a Inpatient Hospital-Acute

SMR

1b Inpatient Hospital-Psychiatric	ic
Service Category Description	
Benefit Description	ć
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 In
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
a puthorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

		Que
		Question
	Marin Trans	
Skilled Nursing Facility (SNF)		
		kesponse
	2 Skilled Nursing Facility (SNF)	2 Skilled Nursing Facility (SNF)

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

2 Skilled Nursing Facility (SNF)		
Service Category Description		
Benefit Description	The state of the s	
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	ADMINIST KACION DE
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No	TO A CONORGE A
Is there an enrollee Coinsurance?	No	Nº 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No	
What is your SNF benefit period?	Original Medicare	Contrato Número
		7

Service Category Description	ry Description	
Benefit Description		
And the second s	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)	Facility (SNF)	
Service Category Description	ry Description	-
Benefit Description	ption	To be a second s
Question	Response	

QUESTION .	RESPONSE
3 Cardiac and Pulmonary Rehabilitation Services	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 SEGUROS DE SALUD
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	\$0.00 M24-000/
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	\$0.00
Services:	

SWR

3 Cardiac and Pulmonary Rehabilitation Services	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	3 Cardiac and Pulmonary Rehabilitation Services
Ser	Service Category Description
	Benefit Description
Question	Response
	4a Emergency Services
Ser	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

Question	The state of the s			Question	7.		1 - 1/0, 47.03 (m)
Response	Benefit Description	Service Category Description	4b Urgently Needed Services	Response	Benefit Description	Service Category Description	4a Emergency Services
2745	The state of the s	Contrato Número	100 C C C	2000	SEGUROS DE SALUD	ADMINISTRACION DB	

4b Urgently Needed Services	
Service Category Description	
Benefit Description	
Respoi	e distribution of the second
į	J. Sans J. J. Sans J. J. Sans
Is there an enrollee Coinsurance?	
Is there an enrollee Copayment?	

4c Worldwide Emergency/Urgent Coverage	verage
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 ADMINISTRACION DE
Is there an enrollee Coinsurance?	No SEGUROS DE CATTE
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	\$0.00 24 - 000 %
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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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
1s a referral required for Partial Hospitalization?	No · ·
6 Home Health Services	One was a surface.
Service Category Description	
Benefit Description	The second secon
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

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Service Category Description

Benefit Description	The second secon	The second secon
Andrew Prince	Response	ADMINISTRACION DE
Cost?	No	SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No	NO O
Is there an enrollee Deductible?	No	# 2 4 - U U Q 4
Is there an enrollee Copayment?	No	

7b Chiropractic Services	is.	
Service Category Description	tion	
Benefit Description		
Question	Response	122/
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes	- Commence of the Commence of
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	ï
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	

Question	Response	ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	SEGUROS DE SALUD
	No	
Is there an enrollee Deductible?	No	
2	No	
Is authorization required?	Yes	Contrato Número
ccupational Therapy Services	No	,

7c Occupational Therapy Services
Service Category Description

7d Physician Specialist Services excluding Psychiatric Services	sychiatric Services	
Service Category Description	on	
Benefit Description		
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	1
Is there an enrollee Coinsurance?	No	ì
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	

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## 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.

ADMINISTRACION DE SEGUROS DE SALUD 1024-0004

Service Category Description

**Benefit Description** 

Response

7f Podiatry Services

Question

7f Podiatry Services	ices	
Service Category Description	scription	<i>\\ \)</i>
Benefit Description	tion	
Question	Response	
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No	10
Is there a service-specific Maximum 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	rofessional Services	
Service Category Description	ry Description	
Benefit Description	scription	
Question	Response	f
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	ADMINISTRACION DE
Is there an enrollee Copayment?	No	SEGUROS DE SALUD
Is authorization required?	No	
Is a referral required for Other Health Care Professional Services?	Yes	#24-0004

Car	No No	Question  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Is there an enrollee Coinsurance?  Is there an enrollee Deductible?
Contrato Número	ric Services ory Description escription	7h Psychiatric Services Service Category Description Benefit Description

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	Primary Car vices; 7e1: vices; 7h1: vetes Self-N	Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:
	<b>₹₽</b> 0	Do you offer an Additional Telehealth henefit for Part B services?
	Response	Question
	194	Benefit Description
Contrato Número	ion	Service Category Description
	efits	7j Additional Telehealth Benefits
Nº 2 4 - 0 0 0 4	No	Is a referral required for Physical Therapy and Speech-Language Pathology Services?
	Yes	Is authorization required?
CONTRACTOR OF TAXABLE	No	Is there an enrollee Copayment?
A DATABLE DACION DR	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Response	Question
	responses and the second	Benefit Description
_	ion	Service Category Description
	Pathology Services	7i Physical Therapy and Speech-Language Pathology Services
		Motes:
	No	As a referral required for Psychiatric Services?
	No	Is authorization required?
	\$0,00	Indicate Maximum Copayment amount for Medicare-covered Group Sessions:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Group Sessions:
1	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:
	No	Is there an enrollee Copayment?
121	Response	Question
den y		Benefit Description
	ion	Service Category Description
7		7h Psychiatric Services

7j Additional Telehealth Benefits	efits	
Service Category Description	ion	
Benefit Description		
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No	A lacatedow
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	The state of the s
Is there an enrollee Copayment?	No	
Is authorization required for Additional Telehealth Benefits?	No	
Is a referral required for Additional Telehealth Benefits?	No	
	2 4 1 1 1 1 1	

maken the state of	to the production of the contract of the contr
7k Opioid Treatment Program Services	es
Service Category Description	
Benefit Description	
vis nieszawiniska karanti kanal famili zani zani famili	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 Opioid Treatment Program Services?	No

8a Outpatient Diagnostic Procedures, Tests and Lab Services	and Lab Services	
Service Category Description	on	
Benefit Description		
Question	Response	We will all the second
service-specific Maximum Enrollee Out-of-Pocket Cost?	No	ADMINIST RACION DE
Is there an enrollee Coinsurance?	No	OBGORUS DE SALUD
Is there an enrollee Deductible?	No	1006-000
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	Contrato Número

SWR

Service Category Description	Lab Services
Benefit Description	
Question	Response
unt 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
	A CONTRACT CONTRACT AND A SECURITY CONTRACT CONT

8b Outpatient Diagnostic and Therapeutic Radiological Services	gical 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 Service Control of the Control of
Is authorization required?	Yes ADMINAS I KACION OR YES
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes SEGUNUS DE CARCO

9a Outpatient Hospital Services	S
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

Question		
Question		
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CALL OF STREET SQUARE SALES	Benefit Description	ce Cate
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The second control of	Benefit Description	Service Category Description
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A significant and a significant of the significant		
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9a Outpatient Hospital Services

	AND THE PARTY OF T
9b Ambulatory Surgical Center (ASC) Services	ervices
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 CECTIFOC DE CALLES
Is there an enrollee Copayment?	No OF CONTROL OF CONTR
Is authorization required?	Yes 10 0 4 - 0 0 0 4
Is a referral required for Ambulatory Surgical Center Services?	Yes

### Is a referral required for Outpatient Substance Abuse? Indicate Maximum Copayment amount for Medicare-covered Individual Sessions: Indicate Minimum Copayment amount for Medicare-covered Individual Sessions: Is there an enrollee Copayment? Is there an enrollee Deductible? Is there an enrollee Coinsurance? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Question Indicate Maximum Copayment amount for Medicare-covered Group Sessions: Indicate Minimum Copayment amount for Medicare-covered Group Sessions: Sauthorization required? **Benefit Description** \$0.00 \$0.00 \$0.00 \$0.00 8 S 8 8 8 8 Response

9c Outpatient Substance Abuse Services
Service Category Description

9d Outpatient Blood Services Service Category Description	rices
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 ADMINISTRACION DE
	SEGUROS DE CALLES

10a Ambulance Services	
Service Category Description	ion
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
As authorization required for non-emergency Medicare services?	Yes
Secret	

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:	32
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved 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 ADMINISTRACION DB
Is there an enrollee Coinsurance?	No SEGUIOS DE SALOD
Is there an enrollee Deductible?	No 10 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No T

	Benefit Description
	Response
Is authorization required?	
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 13i4 - Transportation for Non-Medical Needs.

10b Transportation Services
Service Category Description

11a Durable Medical Equipment (DME)	DME)
Service Category Description	3
Benefit Description	Victoria dell'artico dell'arti
1	Response
m Enrollee Out-of-Pocket Cost?	No
s 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	plies	
Service Category Description	on	,
Benefit Description		
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	ADMINISTRACION DE
Is there an enrollee Coinsurance?	No	SEGUPOS DE SALIDA
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	№24-0004
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	Contrato Número

SWR

## Is authorization required? **Benefit Description** Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form. Yes Response

11b Prosthetics/Medical Supplies Service Category Description

Notes:

Question

11c Diabetic Sunniles and Services and Diabetic Theraneutic Shoes or	ventic Shoes or Inserts
and the state of t	
Service Category Description	
Benefit Description	The second of the second secon
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.

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

12 Dialysis Services			
Service Category Description	on the second se		<u> </u>
Benefit Description			1
	Response	-	1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No		
Is there an enrollee Coinsurance?	No		
Is there an enrollee Deductible?	No		
Is there an enrollee Copayment?	No		1
Is authorization required?	No		
Is a referral required for Dialysis Services?	No		

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## Service Category Description

Benefit Description	and made party appropriate to the party and
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

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

#### 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. Question Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C? Question Question Question Question 13b Over-the-Counter (OTC) Items Service Category Description **Benefit Description Benefit Description Benefit Description Benefit Description Benefit Description** 13a Acupuncture 13c Meal Benefit 13d Other 1 13e Other 2 8 Response 8 Response Response Response Response

Contrato Número

SWR

ADMINISTRACION DE SEGUROS DE SALUD

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13f Other 3	
Service Category Description	
Benefit Description	
Question	Response
13g Dual Eligible SNPs with Highly Integrated Services	sted Services
Service Category Description	3
Benefit Description	
Question	Response
13i Non-Primarily Health Related Benefits for the Chronically	the Chronically III
Service Category Description	
Benefit Description	
Question	Response
14a Medicare-covered Zero Cost-Sharing Preventive Services	ventive 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	ventive Services
Service Category Description	
Benefit Description	
Question	Response ADMINISTRACION DE

Contrato Número

№24-0004

### Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C? Question Service Category Description 14b Annual Physical Exam **Benefit Description** 8 Response

14c Other Defined Supplemental Benefits	efits
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:
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 ADMINIST RACION DE
Is this benefit unlimited?	No SEGUROS DE SALUD
Indicate limit for number of sessions	6
Indicate the number of sessions periodicity;	Every year

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14c Other Defined Supplemental Benefits	efits
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 ADMINISTRACION DB
midicate Maximum Copayment amount for Nutritional/Dietary Benefit:	\$0.00 SEGUROS DE SALUD
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 Contrato Número
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.

14d Kidney Disease Education Services	ion Services	
Service Category Description	cription	
Benefit Description	on	The state of the s
Question	Response	The state of the s
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	
rollee	No	A figure and the second
Is authorization required?	No	
Is a referral required for Kidney Disease Education Services?	No	

Service Category Description		
Benefit Description		
Question	Response	). 441 - 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00	
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00	
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0.00	
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0.00	
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	\$0.00	1
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00	
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00	ADMINISTRACION DE
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00	SEGUROS DE SALUD
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00	
Is authorization required for Medicare-covered Glaucoma Screening?	No	贈24-0004
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No	
Is authorization required for Medicare-covered Barium Enemas?	No	Contrato Número

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#### Is a referral required for any Services? Is authorization required for Medicare-covered EKG following Welcome Visit? Is authorization required for Medicare-covered Digital Rectal Exams? Question **Benefit Description** 8 S 8 Response

14e Other Medicare-Covered Preventive Services
Service Category Description

15 Medicare Part B Rx Drugs and Home Infusion Drugs	usion 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 A DAMINICADA CIONLDE
	SEGUROS DE SALUD

Nº 24-0004

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

## Service Category Description

Benefit Description		
	Response	May a page
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, Extr Surgery, Other Services)	eriodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial
Service Category Description	Ď
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:	
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 ADMINISTRACION DB
Select type of benefit for Extractions:	Mandatory SEGURUS DE SALUD
Is this benefit unlimited for Extractions?	Yes 10.5 / 0.5 0.1
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory N= Z 4 - U U U 4
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

Contrato Número

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	iodontics, Extractions, Prosthodontics, Other Oral/Maxillofacia
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:	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 ADMINISTRACION DE
Is a referral required for Comprehensive Dental Services?	No SEGUROS DE SALUD

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Contrato Número

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#### Is a referral required for Eye Exams? Is authorization required? Is there an enrollee Deductible? Indicate Maximum Copayment amount for Routine Eye Exams: Indicate Maximum Copayment amount for Medicare-covered Benefits Is there an enrollee Copayment? Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there a service-specific Maximum Plan Benefit Coverage amount? Is this benefit unlimited for Routine Eye Exams? Select type of benefit for Routine Eye Exams: Select enhanced benefit: Does the plan provide Eye Exams as a supplemental benefit under Part C? Indicate Minimum Copayment amount for Routine Eye Exams: Indicate Minimum Copayment amount for Medicare-covered Benefits: Is there an enrollee Coinsurance? Select the Routine Eye Exams periodicity: Indicate number of exams for Routine Eye Exams: Service Category Description **Benefit Description** 17a Eye Exams 8 8 \$0.00 \$0.00 \$0.00 \$0,00 8 8 8 8 $\frac{1}{2}$ Every year No, indicate number Mandatory Routine Eye Exams Response ADMINISTRACION DE SEGUROS DE SALUD

17b Eyewear	Contrato Número
Service Category Description	
Benefit Description	J/M S
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

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.	Eyewear benefit maximus benefit amount is combin Provider and/or member plan benefit coverage ar	Notes:
	No	Is a referral required for Eyewear?
Contrato Número	No	Is authorization required?
7	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
1 4 1 0 0 0 4	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:
000	No	Is there an enrollee Copayment?
SEGURUS DE SALUD	No	Is there an enrollee Deductible?
ADMINISTRACION DE	No	Is there an enrollee Coinsurance?
	No	there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Every year	Select the Combined Maximum Plan Benefit Coverage periodicity:
	500.00	Indicate Combined Maximum Plan Benefit Coverage amount:
	Yes	Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?
per period	Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
	Yes	Is this benefit unlimited for Eyeglass frames?
	Mandatory	Select type of benefit for Eyeglass frames:
	Yes	Is this benefit unlimited for Eyeglass lenses?
	Mandatory	Select type of benefit for Eyeglass lenses:
, co	Yes	Is this benefit unlimited for Eyeglasses (lenses and frames)?
	Response	Question
		Benefit Description
	on	Service Category Description
		17b Eyewear

18a Hearing Exams	
Service Category Description	7
Benefit Description	
The same of the sa	Response
xams as a	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

18a Hearing Exams		
Service Category Description	<b>n</b>	1
Benefit Description		1
Question	Response	1
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	
19 by ye'e an enrollee Deductible?	No	
s 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 STG WACION DE	ON DE
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Hearing Aids (all types)

Response Yes

Select enhanced benefits:

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

Service Category Description

Benefit Description

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Contrato Número

18b Hearing Aids

Question

#### 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
1s 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.
The control of the co	

SEGURCS DE SALUD	Response		
ADMINISTRACION DE	and the state of t	Benefit Description	10 m · 10
	ion	Service Category Description	
	rugs/Home Infusion Drugs	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	

Question

1	Response	Question
Contrato Número	Benefit Description	
	Service Category Description	
№24-000.	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	

19a Reduced Cost Sharing for VBID/UF/SSBCI	SBCI
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 III?	
Are you offering a VBID Hospice Benefit?	
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs \should be entered in Section Rx)	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
more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP No	
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	o .
Program Connectedness: Please check the way that advance care plans and/or advance directives are founded from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	22965
Deputfy data sources you plan to use to identify disparities in access, outcomes and/or enrollee	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 borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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, DMINISTRACION DB
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer Part C reductions in cost?	Yes SEGUROS DE SALUD

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Question	U	
benefit offer	No	· · · · · · · · · · · · · · · · · · ·
How many packages do your Additional Benefits contain? (1-15)	<u> </u>	
Question  Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?  How many packages do your Additional Benefits contain? (1-15)	Response No	Co. St. Control of the Control of th

w		19b Additional Benefits for VBID/UF/SSBCI - VBID Package Disease States:	kage 1
		Service Category Description	
		Benefit Description	
PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
1		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
	3	Select all the Non-Medicare-covered additional benefits offered in this package:	13i4: Transportation for Non-Medical Needs; 13i10: General Supports for Living; 13i1: Food and Produce; 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; 13i-O4: Other 4 Non-Primarily Health Related Benefit; 13i-O4: Other 4 Non-Primarily Health Related Benefit; 14c4: Fitness Benefit; 13i3: Pest Control
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	ADMINISTRACION DE SEGUROS DE SALUD
			№24-0004

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#### Disease States:

## Service Category Description

### Benefit Description

							1	1				The state of the s	A STATE OF THE STA	19b - 13i		PBP Section	
										***				Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill		Category	Angres enthrestration comprised them to the total to the total to the total to the total t
Select type of benefit for Pest Control:	Does the plan provide Pest Control as a supplemental benefit under Part C?	Notes:	Is a referral required for Food and Produce?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Food and Produce:	Does the plan provide Food and Produce as a supplemental benefit under Part C?	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Notes:	Question	benefit pescription
Mandatory	Yes	Maximum Plan Benefit Coverage amount on VBID Benefits Card does not carry forward to the next period if it is unused.	No	No	No Contrato Malleto		No	No 1924 - 000	Every month SEGUROS DE SALUI	60.00 ADMINISTRACION DE	Yes	Mandatory	Yes	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	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.	Response	

#### Disease States:

## Service Category Description

### Benefit Description

									Ţ	N								PBP Section Category	4.1. II.
Is this benefit unlimited for number of trips for Any Location?	Description:	Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	Select Plan-approved Location Trips periodicity:	Indicate number of trips for Plan-approved Location:	Is this benefit unlimited for number of trips for Planapproved Location?	Select type of benefit for Plan-approved Location:	Select enhanced benefit:	Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Notes:	Is a referral required for Pest Control?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Question	benent rescription
No	Fleet includes sedans, minivans, buses with hydraulic ramps.	Van; Medical Transport	One-way Contrato Número	Every year	0 24-000	No Lancon DE SAL	Mandatory	Plan-approved Location	Yes	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 BenefitsCard.	No	No	No	No	No	et No	e No	Response	ter der tel p la en .

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#### Disease States:

## Service Category Description

### **Benefit Description**

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

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#### Disease States:

## Service Category Description

### Benefit Description

PBP Section	Category	Question penalt pesciption	Response
	The state of the s	Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	8
		Is a referral required for Indoor Air Quality Equipment and Services?	No
d		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.
T		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
The same of the sa	,	Select type of benefit for Social Needs Benefit:	Mar
		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 No Cost?	
		Is there an enrollee Coinsurance?	8
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	8
	100	Is authorization required?	8
		Is a referral required for Social Needs Benefit?	R

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

#### Disease States:

## Service Category Description

#### **Benefit Description**

Question  Notes:  Does the plan provide Complementary Therapies as supplemental benefit under Part C?
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Resp Social and ito ac impro cogn music conc gardy supp even Yes

#### Disease States:

## Service Category Description

to dealer manual polymer control	The state of the s	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
i\$		Indicate Maximum Plan Benefit Coverage amount:	0.00
i		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?	ADMINISTRACION DE
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SEGUROS DE SALUD
		Is there an enrollee Coinsurance?	No 10 2 4 - 0 0 0 4
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No Contrato Número

#### Disease States:

## Service Category Description

### Benefit Description

		The second secon	the second secon
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.
196 - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Other 1; Other 2; Other 3; Other 4
Egallin is		Enter name of Service:	Home cleaning
		Select type of benefit for Other 1:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	ADMINISTRACION DE SEGUROS DE SALUD
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No 100 % - 000 % C M
,	and an analysis of the contract of the contrac	Is there an enrollee Coinsurance?	No WELT OOO TO
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No Contrato Número
		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.

#### Disease States:

## Service Category Description

#### Benefit Description

												2	A STATE OF THE PARTY OF THE PAR		3	17				1		PBP Section	
					:							\$ T										Category	The state of the s
Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 3:	Enter name of Service:	Notes:	Is a referral required for Other 2 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 2:	Enter name of Service:	Question	Benefit Description
No	No Contrato Número	No	No = 2 + - 0 0 0 4	No	Every month SEGUROS DE SALUD	0.00 ADMINISTRACION DE	Yes	Mandatory	Memory Fitness and Cognitive Function	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.	No	No	No	No	No	t No	Every month	0,00	Yes	Mandatory	Pet care	Response	The street of th

Swy

#### Disease States:

## Service Category Description

		Benefit Description	
PBP Section	Category	Question	Response
.5		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.
V . A		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.

ADMINISTRACION DE SEGUROS DE SALUD

#### **Bid Reports 2024**

#### **PBP Part D 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

ADMINISTRACION DE SEGUROS DE SALUD

№ 24-000 4

Contrato Número

EMR

Region:

Lead Marketing Region:

Org Marketing Name:

Plan Name:

Plan Geographic Name:

Status:

Plan Type:

Enrollee Type:

Number of Tiers:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

Part D Benefit:

Special Needs Plan:

Special Needs Plan Type:

special Needs Flatt Typ

Dual-Eligible SNP:

premiums and cost sharing for enrollees in your D-SNP?

New York

New York

MCS Classicare

MCS Classicare Platino MasCa\$h (HMO D-SNP)

Puerto Rico

Version 4 - Renewal - Successfully exported to desk review

(06/06/23)

OMH

Part A and Part B

N/A

No

US - No

Yes, 00024446

Yes, Defined Standard

Yes

Dual-Eligible

Dual Liigibic

Medicare non-zero dollar cost sharing plan

Under this D-SNP, has the state agreed to cover all Medicare 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	No							
Utilization Management Program								
Pharmacy Network Components	Standard Retail; Out-of-Network; Standard Mail-Order; Long-							
	Term Care							
Notes Available	No							

	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-	\$35.00
Sharing one month supply:	ADMINISTRACION DE
Indicate Insulin Copayment amount for Standard Retail Cost-	SEGUROS DE SALUD \$70.00
Sharing two month supply:	SEGUROS DE SALOD
Indicate Insulin Copayment amount for Standard Retail Cost-	NO 2 / 0 0 0 / \$105.00
Sharing three month supply:	Nº Z 4 - U U U 4
Indicate Insulin Copayment amount for Standard Mail Order	
Cost-Sharing one month supply:	Contrata Numara
Indicate Insulin Copayment amount for Standard Mail Order	Conduct Numeto
Cost-Sharing two month supply:	
Indicate Insulin Copayment amount for Standard Mail Order	\$105.00
Cost-Sharing three month supply:	4 MIC
ndicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy one month supply:	
Indicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care	\$35.00
Pharmacy one month supply:	
Vaccine Attestation:	I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.
Cost Shares Above the Threshold	

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-	Yes			
month supply for the first fill?				
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

EMR

VBID - Part D Benefit Data			
Question Response			
Are you offering Part D Benefits and/or Part D Rewards and	No		
Incentives under the VBID Model?			
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			

De

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#### Bid Reports 2024

#### Plan Service Aréa Report

MCS ADVANTAGE, INC.
H5577-025
VBID, Yes - Pert C.
ANA Landerm M-Erebitis, Yes
Special Exemplemental Benefits for the Orientary, N. No.
Part D Server Saveris Mode. To

Region Lead Marketing Region One, Marketing Name Plan Geographic Name Status

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New York 
1959 York 
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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

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ADMINISTRACION DE SEGUROS DE SALUD

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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 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 MasCa\$h (HMO D-SNP)

Plan Geographic Name: Puerto Ricci

Version 4 - Renewal - Successfully exported to desk review

Status: (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:

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	Yes			
Cost?				
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP)	Lower			
Cost at the Lower, Intermediate or Mandatory Level?				
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00			
Amount:				
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits			
Enrollee Out-of-Pocket cost:				

ADMINISTRACION DE SEGUROS DE SALUD

SMR №24-0004

Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all In-Network Medicare-covered plan services?	
Select all of the In-Network Medicare-covered Service	1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital
Categories that are INCLUDED in the In-Network Maximum	Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2:
Enrollee Out-of-Pocket Cost amount:	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
F	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	2			
packages you are offering?				
Combined Benefits Group 1 Name:	Combined Eyewear and Hearing			
Select which non-Medicare covered benefits are included in	17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames);			
your Combined Supplemental Benefit package:	17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing			
	Aids (all types)			
What is your combined supplemental benefits mode of	Other			
delivery?				
Other Description:	Combined Eyewear and Hearing Allowance			
Is the enrollee limited to one or more of the combined	No			
supplemental benefits from the package which they must				
select in advance?				
Do you offer Combined Supplemental Benefits with a shared	Yes			
maximum plan benefit amount?				
Max Plan Benefit Amount:	500.00			
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every year ADMINISTRACION D			

EMR 24-0004

Contrato Número

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	10b1: Transportation Services - Plan Approved Health-related
your Combined Supplemental Benefit package:	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	No
supplemental benefits from the package which they must	
select in advance?	
Do you offer Combined Supplemental Benefits with a shared	No
maximum plan benefit amount?	
Do you offer Combined Supplemental Benefits with a shared	Yes
visit limit?	
Indicate number of shared visits:	32
Select visit limit periodicity:	Every year

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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

#### 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
1 Contract Nomber	113377	3 Organizació Name	MCS Classicare Platino MasCaSh (HMO D-	5 Emolice Type	700	Traine.
2 Plan ID	029	6 Plan Name	SNP)	10. MA Region:	N/A	
3 Segment ID.	000	? Plan Type	HMO	11. Act Swap/Equiv Apply	N	
4 Contract Year:	2024	8 MA-PD	Υ	12. SNP:	Y	14. SNP Ty e

A. Part B Information		B. Rebate Allocation for Part B Premium	
1 Harland Co. Providence bands and an		1 PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)	\$164.90
Maximum Pt B premium buydown amt . per CMS	\$164.90	2 Part B Rebate Allocation rounded to one decimal (see instructions)	\$164.90



ADMINISTRACION DE SEGUROS DE SALUD

№24-0004



## Appendix C-I Plan Benefit Package (PBP) H5577 – 046

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

Contrato Número

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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:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Segment Geographic Name: Segment ID:

Status

Version 3 - Renewal - Successfully exported to desk review (06/06/23)

Part A and Part B

HMO Inu

\$0.00

N/A

MCS Classicare Platino Total (HMO D-SNP)

MCS Classicare

New York New York Puerto Rico

Plan Type

Enrollee Type:

Part C Plan Premium: Part D Plan Premium:

Visitor/Travel Benefit Available: Continuation Area Available:

Part D Benefit: Formulary:

Special Needs Plan Type: Special Needs Plan:

Dual-Eligible SNP:

Medicare non-zero dollar cost sharing plan

Dual-Eligible

Yes

9 2 8

Yes, Defined Standard

Yes, 00024446

US - No

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:

Question

Plan Level Data

Response

ADMINISTRACION DB SEGUROS DE SALUD

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
ris More 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	The state of the s
Service Category Description	
Benefit Description	The state of the s
Question	Response
1b Inpatient Hospital-Psychiatric	
Service Category Description	A PREMINISTRACION DE
Benefit Description	SEGUROS DE SALUD
Question	Response

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2 2

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

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

1b Inpatient Hospital-Psychiatric	
Service Category Description	
Benefit Description	many comments of the comments
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	the contraction of the contracti
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 ADMINISTRACION DE
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	NO SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No M 2 4 - 0 0 0 4
Is there an enrollee Copayment?	
What is your SNF benefit period?	Original Medicare Contrato Número
	A the representation of the second of the se

SMR

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	ervices
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	\$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 SEGUROS DE SALUD
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00 Ng 2 4 - 0 0 0 4
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00 Contrato Número

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3 Cardiac and Pulmonary Rehabilitation Services	ervices
Service Category Description	
Benefit Description	The state of the s
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	ervices
Service Category Description	
Benefit Description	
Question	Response
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	The second secon
Question	Response ADMINISTRACION DR
4b Urgently Needed Services	SEGUROS DE SALUD
Service Category Description	W24-0004
Benefit Description	
Question	Response Contrato Número

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4b Urgently Needed Services	
Service Category Description	
Benefit Description	The state of the s
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	rage
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 ADMINISTRACION DE
Is there an enrollee Coinsurance?	No SEGUROS DE SATITO
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.



5 Partial Hospitalization	
Service Category Description	5
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	<b>-</b>
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	səjı
Service Category Description	•
Benefit Description	and the second second
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	NO ADMINISTRACION DR
Is there an enrollee Deductible?	No SEGUROS DE SALUD
Is there an enrollee Copayment?	No
	W24-0004
A Comment of the Comm	

7b Chiropractic Services	ces
Service Category Description	ription
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:	9
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
Mere 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	erapy Services	
Service Category Description	y Description	
Benefit Description	cription	The state of the s
Question	Response	SECTIONS RACION DE
a service-specific Maximum Enrollee Out-of-Pc	No	COTUDE OF COMPOSITO
Is there an enrollee Coinsurance?	No	M 2 4 - 0 0 0 4
Is there an enrollee Deductible?	No	>>>
Is there an enrollee Copayment?	No	Contrato M.
Is authorization required?	Yes	planing outrain
Is a referral required for Occupational Therapy Services?	No	

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7d Physician Specialist Services excluding Psychiatric Services	chiatric 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	ices
Service Category Description	
Benefit Description	
Question	Response
s there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
1s 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?	ON
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.
or Budisher Couries	ADWINISTRACIONDE
/I Podiatry Services	SEGUROS DE SALUD
Service Category Description	
Benefit Description	No 2 4 - 0 0 0 4
Question	Response
	Contrato Número

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7f Podiatry Services	ices	
Service Category Description	scription	
Benefit Description	tion	THE CO. I SHEELD
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	sional Services	
Service Category Description	scription	
Benefit Description	tion	
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?	ON	
Is there an enrollee Copayment?	No	
Is authorization required?	No	
Is a referral required for Other Health Care Professional Services?	Yes	
7h Psychiatric Services	vices	
Service Category Description	scription	
Benefit Description	enement of the contract of the	ADMINISTRACION DE
Question	Response SEGUROS DE SALUD	DE SALUD
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No oll	
Is there an enrollee Coinsurance?	000-47-11 ON	000
Is there an enrollee Deductible?	No Contrato Número	Número
Secretary and the second secon		

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7h Psychiatric Services	S
Service Category Description	iption
Benefit Description	The state of the s
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:	
Notes:	
7i Physical Therapy and Speech-Language Pathology Services	ge Pathology Services
Service Category Description	iption
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	enefits
Service Category Description	iption

Benefit Description

Response

Yes

ADMINISTRACION DE SEGUROS DE SALUD

W24-0004

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

Question

Contra

7j Additional Telehealth Benefits	fits
Service Category Description	uo
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	vices
Service Category Description	5
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	and Lab Services	
Service Category Description	uo	
Benefit Description		ADMINISTRACION DE
Question	Response	SEGUROS DE SALUD
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	,
Is there an enrollee Coinsurance?	No	5 000 - 5 7 M
Is there an enrollee Deductible?	No	

8a Outpatient Diagnostic Procedures, Tests and Lab Services	d Lab Services
Service Category Description	
Benefit Description	And the second s
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	logical 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 ADMINISTRACION DE
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	\$0.00 SEGUROS DE SALUD
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	\$0.00

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Yes

2

If a member receives multiple services at the same location on the same day, does only the maximum copay apply?

Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?

Is authorization required?

The state of the s

Benefit bescription           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           Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services:         \$0.00           Indicate Maximum Copayment amount for Medicare-covered Observation Services?         Yes           Is a referral required for Medicare-covered Outpatient Hospital Services?         No           Is a referral required for Medicare-covered Observation Services?         No           Is a referral required for Medicare-covered Observation Services?         No	9a Outpatient Hospital Services	S
Benefit Description  Outpatient Hospital Services: On Services: ion Services: rvices?  Nices?  Service Category Description  Benefit Description	Service Category Description	
Outpatient Hospital Services: Outpatient Hospital Services: on Services: ion Services: rvices? rvices? Service Category Description Benefit Description	Benefit Description	The section of the se
Outpatient Hospital Services: Outpatient Hospital Services: on Services: ion Services: rvices? Nices? Service Category Description Benefit Description	Question	Response
Outpatient Hospital Services: Outpatient Hospital Services: on Services: ion Services: rvices?  Service Category Description  Benefit Description	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Outpatient Hospital Services: Outpatient Hospital Services: on Services: rvices? A Outpatient Hospital Services Service Category Description Benefit Description	Is there an enrollee Coinsurance?	No
Outpatient Hospital Services: Outpatient Hospital Services: on Services: ion Services: rvices? Service Category Description Benefit Description	Is there an enrollee Deductible?	No
Outpatient Hospital Services: Outpatient Hospital Services: on Services: ion Services: rvices?  Na Outpatient Hospital Services Service Category Description Benefit Description	Is there an enrollee Copayment?	No
Outpatient Hospital Services: on Services: rvices? rvices? a Outpatient Hospital Services Service Category Description Benefit Description	Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	\$0.00
on Services:  vices?  es?  a Outpatient Hospital Services  Service Category Description  Benefit Description	Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	00.0\$
ion Services:  rvices?  a Outpatient Hospital Services  Service Category Description  Benefit Description	Indicate Minimum Copayment amount for Medicare-covered Observation Services:	00.0\$
volces? es?  a Outpatient Hospital Services Service Category Description Benefit Description	Indicate Maximum Copayment amount for Medicare-covered Observation Services:	\$0.00
Service Category Description  Benefit Description	Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
9a Outpatient Hospital Services Service Category Description Benefit Description	Its authorization required for Medicare-covered Observation Services?	No
9a Outpatient Hospital Services Service Category Description Benefit Description	Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
9a Outpatient Hospital Services Service Category Description Benefit Description	Is a referral required for Medicare-covered Observation Services?	No
Service Category Description  Benefit Description	9a Outpatient Hospital Service	6
Benefit Description	Service Category Description	
	Benefit Description	
	Question	Response

Service Category Description         Question       Response       ADMINISTRACION DB         Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?       No       ADMINISTRACION DB         Is there an enrollee Coinsurance?       No       SEGUROS DE SALUD         Is there an enrollee Copayment?       No       Image: Common of the co	9b Ambulatory Surgical Center (ASC) Services	enter (ASC) Services	
Benefit Description       Im Enrollee Out-of-Pocket Cost?     No       No     No       No     No       No     No       Yes     Yes	Service Catego	/ Description	
Im Enrollee Out-of-Pocket Cost?  No  No  No  No  No  No  No  No  No  N	Benefit De	cription	
Im Enrollee Out-of-Pocket Cost?       No         No       No         No       No         Yes       Yes		Response	
No N	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	ADMINISTRACION DE
No No Yes	Is there an enrollee Coinsurance?	No	SEGUROS DE SALUD
No Yes  Ory Surgical Center Services?	Is there an enrollee Deductible?	ON	, o vii
Yes	Is there an enrollee Copayment?	No	5 0 0 0 - 5 Z M
Yes	Is authorization required?	Yes	
	Is a referral required for Ambulatory Surgical Center Services?	Yes	Contrato Número

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A Charles and the	
Benefit Description	III.
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:	00'0\$
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
As a referral required for Outpatient Substance Abuse?	No
9d Outpatient Blood Services	Wices
Service Category Description	ription
Benefit Description	u
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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Benefit Description   Report Description	10a Ambulance Services	
## Response  ## Funcillee Out-of-Pocket Cost?  ## No  ##	Service Category Descripti	ē.
um Enrollee Out-of-Pocket Cost?  No  amount for Medicare-covered Ground Ambulance Services:  t amount for Medicare-covered Ground Ambulance Services:  t amount for Medicare-covered Air Ambulance Services:  Services as a supplemental Ambulance Services:  Service Category Description  Beanefit bescription  Beanefit coverage amount?  No ADDMII  No Marchall Treated Location:  Beanefit bescription  No ADDMII  No Marchall Beanefit Coverage amount?  No No Marchall Beanefit Coverage amount Services Service	Benefit Description	t deben en transcriber (1975) de transcriber
No  In amount for Medicare-covered Ground Ambulance Services:  In amount for Medicare-covered Ground Ambulance Services:  It amount for Medicare-covered Ground Ambulance Services:  It amount for Medicare-covered Air Ambulance Services:  In amount for Medicare-covered Air Ambulance Services:  In amount for Medicare-covered Air Ambulance Services:  In amount for Medicare-covered Air Ambulance Services:  Services:  Services:  Services  Services  In amount for Medicare services?  In amount for Medicare-covered Air Ambulance Services:  Services as a supplemental benefit under Part C?  Plan Approved Health-related Location:  Response  Response  Plan Approved Health-related Location:	Question	Response
No  I t amount for Medicare-covered Ground Ambulance Services:  t amount for Medicare-covered Ground Ambulance Services:  t amount for Medicare-covered Ground Ambulance Services:  t amount for Medicare-covered Air Ambulance Services:  pount for Medicare-covered Air Ambulance Services:  t at the Ambulance Services:  Services  Services:  Ser	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
in amount for Medicare-covered Ground Ambulance Services: \$0.00  t amount for Medicare-covered Ground Ambulance Services: \$0.00  ount for Medicare-covered Ground Ambulance Services: \$0.00  ount for Medicare-covered Air Ambulance Services: \$0.00  service Category Description  Benefit Description  Benefit Description  Benefit Description  Mendatory  Approved Health-related Location: \$0.00  Approved Health-related Location: \$0.00  Approved Health-related Location: \$0.00  Approved Health-related Location: \$0.00  Ited Location Trips periodicity: \$0.00  Approved Health-related Location: \$0.00  Ited Location Trips periodicity: \$0.00  One-way  oun Finollee Out-of-Pocket Cost? \$0.00  No ADDMII  No MINOR SEGUL	Is there an enrollee Coinsurance?	No
t amount for Medicare-covered Ground Ambulance Services: \$0.00  tut amount for Medicare-covered Ground Ambulance Services: \$0.00  count for Medicare-covered Air Ambulance Services: \$0.00  count for Medicare-covered Air Ambulance Services: \$0.00  count for Medicare-covered Air Ambulance Services: \$0.00  cenergency Medicare services?  10b Transportation Services  Service Category Description  Benefit Description  Benefit Description  Benefit Description  Approved Health-related Location: No Mandatory  rer of trips for Plan Approved Health-related Location: Come-way  re Plan Approved Health-related Location: Come-way  re Plan Approved Health-related Location: Modern Modical Transport: Other, Description  replan Approved Health-related Location: Modern Modical Transport: Other, Description  rem Plan Approved Health-related Location: No Modical Transport: Other, Description  rem Enrollee Out-of-Pocket Cost? No Modical Transport: Other, Description  No Modical Modic	Is there an enrollee Deductible?	No
t amount for Medicare-covered Ground Ambulance Services: t amount for Medicare-covered Ground Ambulance Services: t amount for Medicare-covered Air Ambulance Services: tount for Services as a supplemental benefit under Part C? Than Approved Health-related Location: Then Approved Health-related Location: The Approved	Is there an enrollee Copayment?	No
t amount for Medicare-covered Ground Ambulance Services: \$0.00  count for Medicare-covered Air Ambulance Services: \$0.00  count for Medicare-covered Air Ambulance Services: \$0.00  cemergency Medicare services?  10b Transportation Services  Service Category Description  Benefit Description  Benefit Description  Response  Services as a supplemental benefit under Part C? Yes  Plan Approved Health-related Location: Mandatory  er of trips for Plan Approved Health-related Location: Every year  r Plan Approved Health-related Location: Fleet includes sedans, minkans, un Plan Approved Health-related Location: Fleet includes sedans, minkans, un Plan Approved Health-related Location: Fleet includes sedans, minkans, un Plan Approved Health-related Location: Fleet includes sedans, minkans, un Plan Benefit Coverage amount?  No ADDMII  No ADDMII  No No NDMII	Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	\$0.00
ount for Medicare-covered Air Ambulance Services:  submit for Medicare-covered Air Ambulance Services:  cemergency Medicare services?  10b Transportation Services  Service Category Description  Benefit bescription  Response  ation Services as a supplemental benefit under Part C?  Plan Approved Health-related Location:  er of trips for Plan Approved Health-related Location:  re of trips for Plan Approved Health-related Location:  Plan Approved Health-related Location:  Response  Mandatory  Mone-way  It Plan Approved Health-related Location:  Response  Mone-way  In Plan Approved Health-related Location:  Response  Mone-way  In Plan Approved Health-related Location:  Response  Mone-way  In Plan Approved Health-related Location:  Response  Mone-way  No ADDMID  No WDMID  No No MEDMID	Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	\$0.00
remergency Medicare services?  10b Transportation Services  Service Category Description  Benefit bescription  Response  ation Services as a supplemental benefit under Part C?  Pian Approved Health-related Location:  re of trips for Plan Approved Health-related Location:  re Plan Approved Health-related Location:  Response  Medical Transport: Other, Description:  re of trips periodicity:  re Plan Approved Health-related Location:  Response  Medical Transport: Other, Description:  In Plan Approved Health-related Location:  Response  Medical Transport: Other, Description:  In Plan Approved Health-related Location:  Response  Medical Transport: Other, Description:  In Plan Approved Health-related Location:  Response  Medical Transport: Other, Description:  No ADDMID  No WEGU  No MO  No MEDICAL MEDI	Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	\$0.00
## Services?    10b Transportation Services   Service Category Description	Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	\$0.00
Service Category Description  Benefit Description  Benefit Description  Benefit Description  Response  Stroke as a supplemental benefit under Part C?  Plan Approved Health-related Location:  Response  Mandatory  Mandatory  Approved Health-related Location:  Plan Approved Health-related	Is authorization required for non-emergency Medicare services?	Yes
Service Category Description  Benefit Description  Benefit Description  Benefit Description  Benefit Description  Response  Yes  Plan Approved Health-related Location:  Response  Mandatory  Mo  Approved Health-related Location:  Ited Location Trips periodicity:  To Plan Approved Health-related Location:  No ADDMIN  No N		ting to the state of the state
Service Category Description         Benefit Description         Response         Part C?       Yes         pproved Health-related Location:       Mandatory         er of trips for Plan Approved Health-related Location:       No         ted Location Trips periodicity:       Every year         r Plan Approved Health-related Location:       Perenty year         or Plan Approved Health-related Location:       Medical Transport; Other, Description Plan Approved Health-related Location:         r Plan Approved Health-related Location:       No         num Plan Benefit Coverage amount?       No         num Enrollee Out-of-Pocket Cost??       No         No       No         No       No         No       No         No       No	10b Transportation Service	u u
Benefit Description         Benefit Description       Response         Betion Services as a supplemental benefit under Part C?       Yes         Piper Approved Health-related Location:       Mandatory         By Approved Health-related Location:       No         Approved Health-related Location:       Every year         In Plan Approved Health-related Location:       One-way         In Plan Approved Health-related Location:       No	Service Category Descripti	
Approved Health-related Location:       No         Approved Health-related Location:       Every year         Approved Health-related Location:       C4         Response       Plan Approved Health-related Location:         Ited Location Trips periodicity:       Done-way         In Plan Approved Health-related Location:       Medical Transport; Other, Description:         In Plan Approved Health-related Location:       No         In Plan Benefit Coverage amount?       No         In Plan Benefit Coverage amount?       No         In Plan Benefit Coverage amount?       No         In Plan Benefit Coverage amount?       No         In Plan Benefit Coverage amount?       No	Benefit Description	
ation Services as a supplemental benefit under Part C?  Plan Approved Health-related Location:  Per of trips for Plan Approved Health-related Location?  Approved Health-related Location:  Revery year  Plan Approved Health-related Location:  Plan	Question	Response
phroved Health-related Location:  er of trips for Plan Approved Health-related Location?  Approved Health-related Location:  ted Location Trips periodicity:  red Location Trips periodicity:  red Location Trips periodicity:  red Location:  red Location Trips periodicity:  red Location:  red Location:  red Location:  Revery year  One-way  Medical Transport; Other, Descriptan Plan Approved Health-related Location:  red Location:  red Location:  red Location:  Red Location:  Medical Transport; Other, Descriptan Plan Benefit Coverage amount?  No ADMIII  No SEGU  No SEGU  No No SEGU  No N	a supplemental benefit under Part	Yes
er of trips for Plan Approved Health-related Location?  Approved Health-related Location:  Approved Health-related Location:  ted Location Trips periodicity:  The Plan Approved Health-related Location:  The Plan Approved Health-related Locat	Select enhanced benefit:	Plan Approved Health-related Location
er of trips for Plan Approved Health-related Location?  Approved Health-related Location:  Ited Location Trips periodicity:  Ited Location Trips periodicity:  Ited Location Trips periodicity:  Ited Location Trips periodicity:  Ited Location:  Medical Transport; Other, Description Plan Approved Health-related Location:  In Plan Approved Health-related Location:  Ited Location:  Medical Transport; Other, Description Plan Benefit Coverage amount?  No ADMID  In Enrollee Out-of-Pocket Cost?  No SEGU  No Mo  No M	Select type of benefit for Plan Approved Health-related Location:	Mandatory
Approved Health-related Location:  ted Location Trips periodicity:  r Plan Approved Health-related Location:  or Plan Approved Health-related Location:  Plan Approved Health-related Location:  Plan Approved Health-related Location:  Pleet includes sedans, minivans, num Plan Benefit Coverage amount?  No ADMID  No SEGU  No No SEGU  No No SEGU  No N	Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
ted Location Trips periodicity:  r Plan Approved Health-related Location:  or Plan Approved Health-related Location:  Fleet includes sedans, minivans, No  No  ADMII  No  SEGU  No  No  No  No  No  No  No  No  No  N	Indicate number of trips for Plan Approved Health-related Location:	24
r Plan Approved Health-related Location:  or Plan Approved Health-related Location:  Fleet includes sedans, minivans, No  No  ADMII  No  SEGU  No  No  No  No  No  No  No  No  No  N	Select Plan Approved Health-related Location Trips periodicity:	Every year
or Plan Approved Health-related Location:  Fleet includes sedans, minivans,  Indical Transport; Other, Description:  Fleet includes sedans, minivans,  No ADMII  No SEGU  No SEGU  No N	Select Type of Transportation for Plan Approved Health-related Location:	One-way
No SEGU  No SEGU  No SEGU  No SEGU  No No SEGU  No No SEGU  No N	Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
No       No       num Enrollee Out-of-Pocket Cost?       No       No       No       No       No       No       No       No       No	Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
num Enrollee Out-of-Pocket Cost? No No No		No
No No No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
ON ON	Is there an enrollee Coinsurance?	
ON	Is there an enrollee Deductible?	
	Is there an enrollee Copayment?	

10b Transportation Services	vices
Service Category Description	ription
Benefit Description	Į.
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 13i4 - Transportation for Non-Medical Needs.
11a Durable Medical Equipment (DME)	nent (DME)
Service Category Description	ription
Benefit Description	The state of the s
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.

# Service Category Description

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Benefit Description	tid for a servence or a department of the first form of the first form of the first

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 ADMINIS	ADMINISTRACION DE
Is there an enrollee Copayment?	No SEGUNC	SECUNOS DE SALUD
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0.00	0
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:		8 000 - 6 Z N

Service Category Description  Question  Is authorization required?  Notes:	
Benefit Description ion norization required?	
i <b>on</b> norization required?	To depute and to cannot be
norization required?	Response
	Yes
	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	eutic Shoes or Inserts
Service Category Description	
Benefit Description	The Company of the Association o
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
ic Shoes or	\$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or \$0.	\$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes: Pre thr	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes: Pre-	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes: thr	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services	So
Service Category Description	ription
Benefit Description	UC
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	ription
Benefit Description	uc
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:	9
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

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Is a referral required for Acupuncture?

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	13a Acupuncture	
	Service Category Description	c
	Benefit Description	1. The second se
Question		Response
	13b Over-the-Counter (OTC) Items	ems
	Service Category Description	c
	Benefit Description	
Question		Response
Does the plan provide Over-The-Counter (OTC) Items as	Items as a supplemental benefit under Part C?	No
	13c Meal Benefit	The special relations of the second s
	Service Category Description	Ľ
	Benefit Description	
Question		Response
Does the plan provide a limited duration Meal Benefit as a Only primarily health-related meals offered in accordance entered in this section.	enefit as a supplemental benefit under Part C? Note: scordance with Chapter 4 of the MMCM should be	No
The state of the s	13d Other 1	
	Service Category Description	Ę
3	Benefit Description	
Question		Response
1.0	13e Other 2	
	Service Category Description	Ē
	Benefit Description	
Ouestion		Response

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13f Other 3	Service Category Description	Benefit Description	Response	13g Dual Eligible SNPs with Highly Integrated Services	Service Category Description	Benefit Description	Response	13i Non-Primarily Health Related Benefits for the Chronically III	Service Category Description	Benefit Description
			Question				Question	The state of the s		A STATE OF THE STA

Benefit Description	
Question	Response
14a Medicare-covered Zero Cost-Sharing Preventive Services	ventive 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	am
Service Category Description	ption
Benefit Description	4
Question	Response
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	No
14c Other Defined Supplemental Benefits	al Benefits
Service Category Description	ption
Benefit Description	Transfer of the transfer of th
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:	Q
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):	s and 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:	9
Select type of benefit for Therapeutic Massage:	Mandatory
Is this benefit unlimited?	No ADMINISTRACION DE
Indicate limit for number of sessions	6 SEGUROS DE SALUD
Indicate the number of sessions periodicity:	Every year

14c Other Defined Supplemental Benefits	efits
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:	00'0\$
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	\$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	00.04
Indicate Minimum Copayment amount for Fitness Benefit:	00.0\$
Indicate Maximum Copayment amount for Fitness Benefit:	\$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	00.0\$
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:* $ADMINISTRACTOMER$	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes: SEGURCS DE SALUD	Therapeutic Massage must be ordered by a physician or medical professional.

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Contrato Número

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14d Kidney Disease Education Services	rices
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	Services
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No ADMINISTRACION DE
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No SECUROS DE SALOD
Is authorization required for Medicare-covered Barium Enemas?	No № 24 - 000 4

14e Other Medicare-Covered Preventive Services	e Services
Service Category Description	
Benefit Description	The state of the s
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	nfusion Drugs
Service Category Description	e
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 ADMINISTRACION DE SEGUROS DE SALUD

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

Surgery, Other Services)		
Service Category Description	ion	
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 Endodontics; Periodontics; Extractions; P. Oral/Maxillofacial Surgery, Other Services	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:	, FI	
Select the Diagnostic Services periodicity:	Every six months	
Select type of benefit for Restorative Services:	Mandatory	
Is this benefit unlimited for Restorative Services?	No, indicate number	
Indicate number of visits for Restorative Services:	-	
Select the Restorative Services periodicity:	Every three years	
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	ADMINISTRACTON DE
Is this benefit unlimited for Extractions?	Yes	SEGUROS DE SALUD
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	2000-47間

Service Category Description  Here the Maximum Plan Benefit Coverage arrount:  Here a service-specific Maximum Plan Benefit Coverage periodicity:  Here a service-specific Maximum Enrollee Out-of-Pocket Cost?  Here an enrollee Colissurance?  Here an enrollee Colissurance?  Here an enrollee Copayment?  Here an enrollee Copayment arrount for Medicare-covered Benefits:  Here an enrollee Copayment arrount for Extractions:  Histore Maximum Copayment arrount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Indices:  Alicate Maximum Copayment arrount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Indices:  Authorization required?	16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Pe Surgery, Other Services)	Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)
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Ideate Minimum Copayment amount for Medicare-covered Benefits:  ### Sound dicate Minimum Copayment amount for Medicare-covered Benefits:  ### Sound dicate Minimum Copayment amount for Mon-routine Services:  ### Sound dicate Minimum Copayment amount for Non-routine Services:  ### Sound dicate Minimum Copayment amount for Restorative Services:  ### Sound dicate Minimum Copayment amount for Restorative Services:  ### Sound dicate Maximum Copayment amount for Endodontics:  ### Sound dicate Maximum Copayment amount for Periodontics:  ### Sound dicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  ### Sound dicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  ### Sound dicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  #### Sound dicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  #### Sound dicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  ##### Sound dicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  ###################################	Is there an enrollee Deductible?	No
ficate Minimum Copayment amount for Medicare-covered Benefits:  \$0.00  ficate Maximum Copayment amount for Non-routine Services:  \$0.00  ficate Minimum Copayment amount for Non-routine Services:  \$0.00  ficate Minimum Copayment amount for Restorative Services:  \$0.00  ficate Minimum Copayment amount for Restorative Services:  \$0.00  ficate Minimum Copayment amount for Restorative Services:  \$0.00  ficate Minimum Copayment amount for Periodontics:  \$0.00  ficate Minimum Copayment amount for Periodontics:  \$0.00  ficate Maximum Copayment amount for Periodontics:  \$0.00  ficate Maximum Copayment amount for Extractions:  ficate Maximum Copayment amount for Extractions:  ficate Maximum Copayment amount for Extractions:  ficate Maximum Copayment amount for Periodontics, Other Oral/Maxillofacial Surgery, Other  \$0.00  ficate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  \$0.00  ficate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  \$0.00  ficate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  \$0.00  ficate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  \$0.00  ficate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  ### April	My there an enrollee Copayment?	No
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authorization required?	_	\$0.00
Carolina Charles and Charles and Carolina Charles and	Is authorization required?	
a referral required for Comprenensive Dental Services?	Is a referral required for Comprehensive Dental Services?	No SHICKOLD DE STEEDE DE STITUT
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M24-0004

Contrato Número

EMR

17a Eye Exams

## Service Category Description

#### Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
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?	ON
Is there an enrollee Coinsurance?	No
As 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 Eve Exams?	No

#### 17b Eyewear

## Service Category Description

### Benefit Description

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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 ADMINISTRACION DE
Is this benefit unlimited for Contact lenses?	Yes SEGURCS DE SALUD
Select type of benefit for Evedlasses (lenses and frames):	Mandatory

W24-0004

17b Eyewear	
Service Category Description	ption
Benefit Description	The state of the s
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 NOTO A STRINISH ON
Ts there an enrollee Coinsurance?	No SEGUROS DE SALID
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No No 2 4 - 0 0 0 4
Indicate Minimum Copayment amount for Medicare-covered Benefits:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	\$0.00
Is authorization required?	No 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
rt C?	
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid

18a Hearing Exams	
Service Category Description	5
Benefit Description	and the second s
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:	
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:	,
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
s 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	SEGUROS DE SALUD

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Contrato Número

Hearing Aids (all types)

Does the plan provide Hearing Aids as a supplemental benefit under Part C? Select enhanced benefits:

Question

**Response** Yes

Service Category Description Benefit Description

18b Hearing Aids	
Service Category Description	noi
Benefit Description	The Control of Control
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?	Aes
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	rugs/Home Infusion Drugs
Service Category Description	lo
Benefit Description	and course (management) and
Question	Response
20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	rugs/Home Infusion Drugs
Service Category Description	
Benefit Description	N24-0004
Question	Response
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Contrato Número

A A B

19a Reduced Cost Sharing for VBID/UF/SSBCI	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 III?	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	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
ly:	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 borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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 ADMINISTRACION DE
	SEGUROS DE SALUD

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Benefit
Additional
19b

Question	Response
	No
How many packages do your Additional Benefits contain? (1-15)	F

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

#### Disease States:

## Service Category Description

#### **Benefit Description**

6	The second district of		
PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	ckage app or SSBCI?	VBID
800		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:	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:	1310: General Supports for Living; 13i1: 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 ADMINISTRACTON DE
		Is there a package level maximum coverage amount?	No SEGUROS DE SALUD

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Contrato Número

22/17

		19b Additional Benefits for VBID/UF/SSBCI - VBID Package	age 1
		Disease States:	
		Service Category Description	
	po e	Benefit Description	1000 000 000 000 000 000 000 000 000 00
PBP Section	Category	Question	Response
		Notes:	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 filled under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The third benefit is Transportation for Non-Medical Needs.
196 - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically III 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:	250.00
		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 ADMINISTRACION DE
		Select type of benefit for Pest Control:	Mandatory SEGUROS DE SALUD

1024-0004 MR

	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	kage 1
	Disease States:	
	Service Category Description	
	Benefit Description	2.7
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
The state of the s	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 Planapproved 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 ADMINISTRACION DE SEGUROS DE SALUD

1124-0004

19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		Service Category Description	The second of th	Response	0	Every year	One-way	Van; Medical Transport	Fleet includes sedans, minivans, buses with hydraulic ramps.	No	No	No	No	No	No	No	Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.	Yes	Mandatory	Yes	0.00	Every month ADMINISTRACION DE	No SEGUROS DE SALUD	7 0 0 0 - 7 C 9
	Disease States:		Benefit Description	Question	Indicate number of trips for Any Location:	Select Any Location Trips periodicity:	Select Type of Transportation for Non-Medical Needs for Any Location:	Select Mode of Transportation for Non-Medical Needs for Any Location:	Description:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?	Is there an enrollee Deductible?	Is there an enrollee Copayment?	Is authorization required?	Is a referral required for Transportation for Non-Medical Needs?	Notes:	Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?	Select type of benefit for Indoor Air Quality Equipment and Services:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Indicate Maximum Plan Benefit Coverage amount:	Select Maximum Plan Benefit Coverage periodicity:	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there an enrollee Coinsurance?
				PBP Section Category	William Control of the Control of th																		Ċ	

		19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	kage 1
		Disease States:	
		Service Category Description	
		Benefit Description	and the second s
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.
The state of the s		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
T.		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

ADMINISTRACION DE SEGURCS DE SALUD

Contrato Número SMR 37/42 W24-0004

ription  apies as a  Therapies: enefit Coverage mount: iodicity: ee Out-of-Pocket.			19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	kage 1
Service Category  Category  Notes:  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit under Part C?  Select type of benefit Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Is there an enrollee Cohsurance?  Is there an enrollee Cohsurance?  Is there an enrollee Cobayment?  Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DB  SEGUROS DE SALUD.  SEGUROS DE SALUD.			Disease States:	
Category   Question			Service Category Description	
Category  Notes:  Does the plan provide Complementary Therapies as a supplemental benefit under Part C? Select type of benefit for Complementary Therapies: Is there a service-specific Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Is there a nervice-specific Maximum Emollee Out-of-Pocket Cost? Is there an emollee Cohasurance? Is there an emollee Cohasurance? Is authorization required? Is a referral required for Complementary Therapies? Notes:  ADMINISTRACION DB SEGUND.		And the second of the second o	Benefit Description	The state of the s
Notes:  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there an enrollee Coinsurance?  Is there an enrollee Deductible?  Is there an enrollee Copayment?  Is authorization required?  Is a referral required for Complementary Therapies?  Notes:  ADYATMESTRACION DB  SEGUROS DE SALUD.	PBP Section	Category	Question	Response
Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount?  Indicate Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there an enrollee Coinsurance?  Is there an enrollee Coinsurance?  Is there an enrollee Copayment?  Is authorization required?  Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DE  SEGUROS DE SALUD.			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, counselling. 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.
Select type of benefit for Complementary Therapies: Is there a service-specific Maximum Plan Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage periodicity: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there an enrollee Coinsurance? Is there an enrollee Copayment? Is authorization required? Is a referral required for Complementary Therapies? Notes:  ADMINISTRACION DB SEGUROS DE SALUD.			ary Therapies as	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount? Indicate Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage amount: Select Maximum Plan Benefit Coverage amount: Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there an enrollee Coinsurance? Is there an enrollee Copayment? Is authorization required? Is a referral required for Complementary Therapies? Notes:  ADMINISTRACION DE SALUD.  ADMINISTRACION DE SALUD.	Contract of the Contract of th		Select type of benefit for Complementary Therapies:	Mandatory
Indicate Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket. Cost?  Is there an enrollee Coinsurance? Is there an enrollee Copayment? Is authorization required? Is a seferial required for Complementary Therapies?  Notes:  ADMINISTRACION DE SEGUROS DE SALUD.  ADMINISTRACION DE SEGUROS DE SALUD.			Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select Maximum Plan Benefit Coverage periodicity: Is there a service-specific Maximum Enrollee Out-of-Pocket. Cost? Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment? Is authorization required? Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DB SEGUROS DE SALUD.			Indicate Maximum Plan Benefit Coverage amount:	0.00
Is there a service-specific Maximum Enrollee Out-of-Pocket. Cost? Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment?. Is authorization required? Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DE SEGUROS DE SALUD.			Select Maximum Plan Benefit Coverage periodicity:	Every month
Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment? Is authorization required? Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DE SEGUROS DE SALUD.			Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Deductible? Is there an enrollee Copayment? Is authorization required? Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DE SEGUROS DE SALUD.  12 4 - 0 0 0 4			Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?.  Is authorization required?  Is a referral required for Complementary Therapies?  Notes:  ADMINISTRACION DE SEGUROS DE SALUD.  12 4 - 0 0 0 4			Is there an enrollee Deductible?	No
horization required?  sferral required for Complementary Therapies?  ADMINISTRACION DE  SEGUROS DE SALUD.  12 4 - 0 0 0 4		\$	Is there an enrollee Copayment?	No.
sferral required for Complementary Therapies?  ADMINISTRACION DE SEGUROS DE SALUD.  12 4 - 0 0 0 4			Is authorization required?	No
ADMINISTRACION DE SEGUROS DE SALUD.			Is a referral required for Complementary Therapies?	No
		A de		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 prebiotic or probiotic products are also commonly used (NCCIM, 2016a).

Contrato Número & M. R.

	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	kage 1
	Disease States:	
	Service Category Description	
	Benefit Description	The state of the s
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
The state of the s	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 SEGUROS DE SALUD
	Is there an enrollee Deductible?	No
	Is there an enrollee Copayment?	5 0 0 0 - 5 7 M on

ent the		19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	kage 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.
19h 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III 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 ADMINISTRACION DE SEGUROS DE SALUD
		Is there a service-specific Maximum Enrollee Out-of-Packet Cost?	No
		Is there an enrollee Coinsurance?	No P 2 2 1
		Is there an enrollee Deductible?	No
	1	Is there an enrollee Copayment?	No Contrato Número
		Is authorization required?	No 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
	1		

PBP Section			
		Disease States:	
		Service Category Description	
		Benefit Description	Annual Hamilton and American
	Category	Question	Response
	Total Control of the	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
	ti p toman i made	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
No. of the last		Is authorization required?	No
1		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 ADMINISTRACION DE
		Is there an enrollee Copayment?	No SEGUROS DE SALUD
	i	Is authorization required?	No
		Is a referral required for Other 3 Services?	oN № 2 4 = 0 0 0 4

		19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	ckage 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.
Vanco	da v	Enter name of Service:	Hairstyling
		Select type of benefit for Other 4:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
The state of the s		Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?	L No
		Is there an enrollee Coinsurance?	No
- Contract		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.

ADMINISTRACION DE SEGUROS DE SALUD

W24-0004

Contrato Número

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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 III: No

Part D Senior Savings Model: No

ADMINISTRACION DE SEGUROS DE SALUD

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Contrato Número

Region:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Status:

Plan Type:

Enrollee Type:

Number of Tiers:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

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?

Part D Benefit:

New York

New York

MCS Classicare

Puerto Rico

(06/06/23)

Part A and Part B

НМО

N/A

No

US - No

Dual-Eligible

Yes, 00024446

Yes, Defined Standard

Medicare non-zero dollar cost sharing plan

MCS Classicare Platino Total (HMO D-SNI

Version 3 - Renewal - Successfully exported to desk review

Yes

Yes

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

Part D Bo	enefit 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	No
Utilization Management Program	
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-	\$35.00
Sharing one month supply:	
Indicate Insulin Copayment amount for Standard Retail Cost-	\$70.00
Sharing two month supply:	ADMINISTRACION DE
Indicate Insulin Copayment amount for Standard Retail Cost-	SEGUROS DE SALUD \$105.00
Sharing three month supply:	Ho Co. /
Indicate Insulin Copayment amount for Standard Mail Order	№24-000 A
Cost-Sharing one month supply:	3 3 3 4 1
Indicate Insulin Copayment amount for Standard Mail Order	Cantana
Cost-Sharing two month supply:	Contrato Número
Indicate Insulin Copayment amount for Standard Mail Order	\$105.00
Cost-Sharing three month supply:	7 MIC
Indicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy one month supply:	
mdicate Insulin Copayment amount for Out-of-Network	\$35.00
Pharmacy other day supply:	
Indicate Insulin Copayment Amount for Long Term Care	\$35.00
Pharmacy one month supply:	
Vaccine Attestation:	I attest that there is no deductible and no cost sharing for an adult vaccine recommended by the Advisory Committee on Immunization Practices (ACIP). There is no enrollee cost sharing on the ingredient cost of the vaccine submitted on the prescription drug event (PDE) record, or any associated sales tax, dispensing fee, or vaccine administration fee, regardless of tier placement or benefit phase. The applicable vaccines will be designated as such on the beneficiary-facing formulary model documents.
Cost Shares Above the Threshold	

Gen	eral 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-	Yes
month supply for the first fill?	
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

M3

VBID - Part I	) 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 SEGUROS DE SALUD

№24-0004

Contrato Número

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## Bid Reports 2024

### Plan Service Area Report

MCS ADVANTAGE, BYC.
H5577 - 046
VBID. Visi - Part C.
MA Uniforms; pre-laids; Bio
Special Supplemental Benefits for the Chromically B1 Not
Port D Service Savings Model: No

Statio
Plan Type
Principle Type
Principle

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

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P	ucrto Rico	Aguas Buchas	40040	NO NO	No	Zrgcooc.'s . 00603 00604 00605 day 0 No
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	40749 40753 40769	40735 No. 40757 No. 40779 No. 40779 No.	40395 No No No 40349 No 4053 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 III: No

Part D Senior Savings Model: No

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:

New York

New York

MCS Classicare

MCS Classicare Platino Total (HMO D-SNP)

Puerto Rico

Version 3 - Renewal - Successfully exported to desk review

(06/06/23)

НМО

Part A and Part B

\$0.00

N/A

No

US - No

Yes, 00024446 Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

SEGUROS DE SALUD

ADMINISTRACION DE

№ 2 4 - 0 0 0 **4** 

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

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	Yes	
Cost?		
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP)	Lower	
Cost at the Lower, Intermediate or Mandatory Level?		
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost Amount:	3400.00	
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits	
Enrollee Out-of-Pocket cost:		

Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all In-Network Medicare-covered plan services?	
Select all of the In-Network Medicare-covered Service	1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital
Categories that are INCLUDED in the In-Network Maximum	Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2:
Enrollee Out-of-Pocket Cost amount:	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	2	
packages you are offering?		
Combined Benefits Group 1 Name:	Combined Eyewear and Hearing	
Select which non-Medicare covered benefits are included in	17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames);	
your Combined Supplemental Benefit package:	17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing	
	Aids (all types)	
What is your combined supplemental benefits mode of	Other	
delivery?		
Other Description:	Combined Eyewear and Hearing Allowance	
Is the enrollee limited to one or more of the combined	No	
supplemental benefits from the package which they must		
select in advance?		
Do you offer Combined Supplemental Benefits with a shared	Yes	
maximum plan benefit amount?	ADMINISTRACION I	
Max Plan Benefit Amount:	700.00 SEGUROS DE SALUI	
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every year	

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

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№ 2 4 - 0 0 0 4

ADMINISTRACION DE SEGUROS DE SALUD

## WORKSHEET 6 - MA BID SUMMARY

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

\$5.05
\$0.00
\$0.00

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ADMINISTRACION DE

SEGUROS DE SALUD

№24-0004



## Appendix C-I Plan Benefit Package (PBP)

H5577 – 054

ADMINISTRACION DE SEGUROS DE SALUD;

№ 2 4 - 0 0 0 4



## **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

Org. Marketing Name: Lead Marketing Region:

Segment ID: Plan Geographic Name: Plan Name:

MCS Classicare Platino Maximo (HMO D-SNP)

MCS Classicare

New York New York

Puerto Rico

Segment Seographic Name:

Plan Type:

Part C Plan Premium: Part D Plan Premium: formilled Type:

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:

Question

\$0.00 N/A

Part A and Part B

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

Region 1

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

N 8 8

Plan Level Data

Response

ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

Tiered Cost sharing for Part B Services	vices
	And the state of t
(Please PBP sof	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 No care?	No
1s 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
	Approximate Condenses Condenses Condenses of

Question	A CARLO STATE OF THE STATE OF T		
Question	Benefit Description	Service Category Description	1a Inpatient Hospital-Acute
AMERICAN AND AND AND AND AND AND AND AND AND A			

Service Cat	To Inpatient nos
egory Des	10Spital-P
scription	Sychiatric

מפו אורם השומשטים א הפסירו ויהוי		
Benefit Description	The state of the s	ADMINISTRACION DE
Andread and the state of the st	espo	SEGUROS DE SALUD
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	124-0004

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	

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Service Category Description

**Benefit Description** 

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Question

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description	ATT COMPANY OF THE CO	Parties of Company of the Company of
Question	Response	Military Commission of the force
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 AL	ADMINISTRACION DE
Is there an enrollee Coinsurance?	No SI	EGUROS DE SALUD
Is there an enrollee Copayment?	No	0001
What is your SNF benefit period?	Original Medicare	12 4 - U U U 4

2 Skilled Nursing Facility (SNF)	SNF)
Service Category Description	ption
<b>B</b>	
	Response
Do you charge cost sharing on the day of discharge?	
Is authorization required?	Yes
Is a referral required for SNF Services?	Yes
2 Skilled Nursing Facility (SNF)	SNF)

			Question	
Service Category Description	3 Cardiac and Pulmonary Rehabilitation Services	The state of the s	Question	Benefit Description

Service Category Description

3 Cardiac and Pulmonary Rehabilitation Services	ervices
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 ADMINISTRACION DE SEGUROS DE SALUD
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00 Nº 2 4 - 0 0 0 4

3 Cardiac and Pulmonary Rehabilitation Services	Services
Service Category Description	
Benefit Description	
per service for Medicare-covered Supervised Exercise Therapy ry Disease (PAD) Services:	
ent amount per service for Medicare-covered Supervised Exercise Therapy ipheral Artery Disease (PAD) Services:	\$0.00
Is authorization required?	Yes
Is a referral required for Cardiac and Pulmonary Rehabilitation Services?	No

	Benefit Description
	Service Category Description
	4a Emergency Services
No	
No	Is there an enrollee Coinsurance?
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Response	an Boar to a titra and affects to the facilities and
AND THE CONTROL AND THE CONTRO	Benefit Description
	Service Category Description
	4a Emergency Services
4397	Question
The second secon	Benefit Description
	Service Category Description
ervices	3 Cardiac and Pulmonary Rehabilitation Services
	The state of the s

Response

Nº24-0004

ADMINISTRACION DE SEGUROS DE SALUD

Question

4b Urgently Needed Services
Service Category Description
Benefit Description

4b Urgently Needed Services	
Service Category Description	
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
	No
Is there an enrollee Copayment?	No
A COLUMN TO THE PARTY OF THE PA	Long take Long to the long that

4c Worldwide Emergency/Urgent Coverage	rerage
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.

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

Contrato Número

o ratual nospitalization	
Service Category Description	ription
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	
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	
A STATE OF THE PARTY OF	Question	Response
-	ım Enrollee Out-ı	
X	Is there an enrollee Coinsurance?	
	Is there an enrollee Deductible?	No
	Is there an enrollee Copayment?	A supposition of
	uired?	Yes
	Is a referral required for Home Health Services?	Yes

7a Primary Care Physician Services

Service Category Description

Benefit Description	CONTINUENT OF THE CONTINUENT O
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
;5	No
Is there an enrollee Deductible?	
Is there an enrollee Copayment?	No SEGUINOS DE SANCIONO

7b Chiropractic Services	
Service Category Description	ion
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
15 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	rvices	
Service Category Description	ition	
Benefit Description		
Question	Response	
ım Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	SEGUROS DE SALUD
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	1624-0004
Is authorization required?	Yes	1
Is a referral required for Occupational Therapy Services?	No	Contrato Número
S The second sec		

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7d Physician Specialist Services excluding Psychiatric Servic	xcluding Psychiatric Services
Service Category Description	Description
Benefit Description	
Is there a service-specific Maximum 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
The first contract of the cont	The second secon

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:	
7f Podiatry Services	CILITY THE STATE OF THE STATE O

Service Category Description

Benefit Description

Question

Response

Nº24-0004 Contrato Número

7f Podiatry Services	es
Service Category Description	cription
Benefit Description	on
Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	
Is there a service-specific Maximum 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
and the second s	

7g Other Health Care Professional Services	nal Services
Service Category Description	ption
Question	ISE
Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
2	
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description	ion	ADMINISTRACION DE
Benefit Description		ADMINISTRACION DE
TOTAL TOTAL CONTINUE VICTOR OF THE TOTAL CONTINUE OF THE TOTAL CON	Response	OF GOVERNMENT OF STREET
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	10 0 A = 0 0 0 A
Is there an enrollee Coinsurance?	No	
	No	
· ·	,	Contrato Número

7h Psychiatric Services Service Category Description	rvices	
	tion	
	Response	ongo co
Is there an enrollee Copayment?		
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:		The state of the s
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:		
Is authorization required?	No	
Is a referral required for Psychiatric Services?	No	

7i Physical Therapy and Speech-Language Pathology Services	Pathology Services	
Service Category Description	tion	
Benefit Description		
	Response	Andrew Controlled Cont
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	ADMINISTRACION DE
Is there an enrollee Copayment?	No	SEGUROS DE SALUD
	Yes	
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No	Nº 2 4 - 0 0 0 4

7j Additional Telehealth Benefits	ts Contrato Número
Service Category Description	
Benefit Description	
Question	
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	its
Benefit Description	
Question	
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?	
Is a referral required for Additional Telehealth Benefits?	No
The proper of the control of the con	AMERICA AMERICA MARKATAN AND THE TOTAL THE PARTY OF THE P

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services	s and Lab Services	
Service Category Description	ion	
Benefit Description		
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	medication files - Engineeric file
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	ADMINISTRACION
Is there an enrollee Copayment?	No	SEGUROS DE SALO
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	000
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	1000 - 4 乙酯
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	\$0.00	1
		Contrato Número

8a Outpatient Diagnostic Procedures, Tests and Lab Service	Lab Services
Service Category Description	
Question	
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 No copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes
	the reference of

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 ADMINISTRACION DB

SEGUROS DE SALUD

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9a Outpatient Hospital Services	(A)
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	v)

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Services

# Service Category Description

	Benefit Description
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	<b>Benefit Description</b>
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Question

9b Ambulatory Surgical Center (ASC) Services	(ASC) Services	
Service Category Description	cription	
Benefit Description	on	ADMINISTRACION DE
Question	Response	SEGUROS DE SALUD
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	)
Is there an enrollee Coinsurance?	No	Nº 2 4 - 0 0 0 4
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	Contrato Número
Is authorization required?	Yes	
Is a referral required for Ambulatory Surgical Center Services?	Yes	

9c Outpatient Substance Abuse Services	ione
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	The state of the s
Service Category Description	
Direction	Pernance
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 A JAGINITAL A CITY ON
Is authorization required?	No SEQUEDOS DE SALLEY
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services	
Service Category Description	חמ
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	OS .
Service Category Description	ion
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 No A CIONI DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No N
Is there an enrollee Coinsurance?	No SECONO DE CAMO
Is there an enrollee Deductible?	No 0 0 0 - 2 0 0 0 4
Is there an enrollee Copayment?	No

10b Transportation Services	es
Service Category Description	tion
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 13i4 - Transportation for Non-Medical Needs.

11a Durable Medical Equipment (DME) Service Category Description	DME)
Benefit Description	
Question	Response
-specific Maximum 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	plies	Te de la companya de
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	AGMINISTRACION
Is there an enrollee Copayment?	No	SEGUROS DE SALUD
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	№24=0004
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enterested to the second of th	All Control and the control of the c
Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.	Notes:
Yes	Is authorization required?
Response	Question
C LONG THE STATE OF THE STATE O	Benefit Description
ön	Service Category Description
plies	11b Prosthetics/Medical Supplies

And the state of t	The state of the s
11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts	eutic 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
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.

ADMINISTRACION DE SEGUROS DE SALUD

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12 Dialysis Services	
Service Category Description	
Benefit Description	
	The state of the s
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
?	No
an enrollee Deductible?	No
Is there an enrollee Copayment?	No
	No
Is a referral required for Dialysis Services?	No .

	13a	
,	Acupuncture	
	rø	

## Service Category Description

## **Benefit 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 ADMINISTRACIONINE.

SEGUROS DE SALUD

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Response	Question
	Benefit Description
	Service Category Description
**************************************	13e Other 2
Response	Question
The state of the control of the state of the	Benefit Description
	Service Category Description
27 (27)	13d Other 1
No	Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.
Response	Question
	Benefit Description
	Service Category Description
	13c Meal Benefit
No	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?
Response	Question
The second secon	Benefit Description
	Service Category Description
15	13b Over-the-Counter (OTC) Items
Response	Question
And the state of t	Benefit Description
	Service Category Description
	13a Acupuncture
	,

ADMINISTRACION DE SEGUROS DE SALUD

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Question			A THE STATE OF THE	Question	de la companya de la		
Question	Benefit Description	Service Category Description	13g Dual Eligible SNPs with Highly Integrated Services	Response	Benefit Description	Service Category Description	13i Other 3
	And the second s	ion	grated Services	Response	The second secon	ion	
All and a management of the land discharge in the property of them, and the first them are the	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		:	erinere, a	Chance to a service of the service o		

13i Non-Primarily Health Related Benefits for the Chronically	Chronically III
Service Category Description	
Benefit Description	
Question	Response
14a Medicare-covered Zero Cost-Sharing Preventive Services	ntive Services
Service Category Description	
Benefit Description	The control of the co
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

14a Medicare-covered Zero Cost-Sharing Preventive Services

N

Service Category Description

Benefit Description Response ADMINISTRACION DE SEGUROS DE SALUD

Question

Is a referral required?

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14b Annual Physical Exam  Service Category Description  Benefit Description  Question  Question  Response  No	and the state of t	The state of the s
14b Annual Physical Exam  Service Category Description  Benefit Description  Response	No	Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?
14b Annual Physical Exam Service Category Description Benefit Description		Question
	- 1 To 1 T	Transfer of Agriculture (Agriculture of Agriculture
		Service Category Description
		14b Annual Physical Exam

market and the control of the contro	the state of the s
14c Other Defined Supplemental Benefits	efits
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 ADMINISTRACION DE
Indicate limit for number of sessions	6 SEGUROS DE SALUD
Indicate the number of sessions periodicity:	Every year

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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 ADMINISTRACION DE
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	\$0.00 SEGUROS DE SALUD
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 Contrato Número
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.

14d Kidney Disease Education Services	ices
Service Category Description	
Benefit Description	
Question	Response
um Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
quired?	
Is a referral required for Kidney Disease Education Services?	

14e Other Medicare-Covered Preventive Services	Services
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0,00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0,00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00 SELITOS DE SALITO
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 Commato Numero

14e Other Medicare-Covered Preventive Services	ive Services
Service Category Description	on
Benefit Description	
	and the state of t
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
D)	No

15 Medicare Part B Rx Drugs and Home Infusion Drugs	sion 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.
Ts 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 SEGUROS DE SALUD

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SMR

### Does the plan provide Preventive Dental Items as a supplemental benefit under Part C? Question 16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description **Benefit Description** S Response

# Service Category Description Benefit Description

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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:	<b>)</b>
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:	P
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 ADMINISTRACION DE
Is this benefit unlimited for Extractions?	Yes SEGUROS DE SALUE
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 1224 - 0004
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Contrato Número EMR 26/42

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Ex Surgery, Other Services)	OUDINICS, EXITACTIONS, FIUSTINOUDINICS, OTHER OTAL/MAXIIIOTACIAL
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:	Еvery 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 VENTINE A CTON DR
	SEGUROS DE SALUD

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Contrato Número MK 27/42

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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## Service Category Description

Benefit Description		
	i	
under Part C?	Yes	
Select enhanced benefits:	Contact lenses; Eyegl Eyeglass frames	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
t type of benefit for Contact lenses:	Mandatory	ADMINISTRACION DB
Is this benefit unlimited for Contact lenses?	Yes	SEGUROS DE SALUD
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory	

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Contrato Número MR 28/42

Contrato Número	Is a referral required for Eyewear?
	Is authorization required?
\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
	Indicave Minimum Copayment amount for Medicare-covered Benefits:
	Is there an enrollee Copayment?
ADMINISTRACION DE	Is there an enrollee Deductible?
and the second s	Is there an enrollee Coinsurance?
1 1 2	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Every year	Select the Combined Maximum Plan Benefit Coverage periodicity:
600.00	Indicate Combined Maximum Plan Benefit Coverage amount:
S	Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?
Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
S	Is there a service-specific Maximum Plan Benefit Coverage amount?
S	Is this benefit unlimited for Eyeglass frames?
Mandatory	Select type of benefit for Eyeglass frames:
\$	Is this benefit unlimited for Eyeglass lenses?
Mandatory	Select type of benefit for Eyeglass lenses:
S	Is this benefit unlimited for Eyeglasses (lenses and frames)?
Response	Question
* 125 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Benefit Description
	Service Category Description
	17b Eyewear

	Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Question	Benefit Description	Service Category Description	18a Hearing Exams
Routine Hearing Exams; Fitting/Evaluation for Hearing Aid	Yes	Response	AAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAAA		

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.

Benefit Description	
Benefit Description	
And the contract of the contra	Man to the state of the state o
Question	Onse
Select type of benefit for Routine Hearing Exams:	atory
Is this benefit unlimited for Routine Hearing Exams?	dicate number
Indicate number for Routine Hearing Exams:	
Select Routine Hearing Exams periodicity:	уеаг
Select type of benefit for Fitting/Evaluation for Hearing Aid:	etory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	dicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	
Select Fitting/Evaluation for Hearing Aid periodicity:	year
Is there a service-specific Maximum Plan Benefit Coverage amount?	
Is there an enrollee Deductible?	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	
Is there an enrollee Copayment?	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	The second secon
Indicate Maximum Copayment amount for Medicare-covered Benefits:	Andread to the first the second secon
Indicate Minimum Copayment amount for Routine Hearing Exams:	
Indicate Maximum Copayment amount for Routine Hearing Exams:	
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid: \$0.00	
Is authorization required?	A CARLOS CALLED TO THE CALLED
Is a referral required for Hearing Exams?	
The state of the s	ADMINISTRACION DE

Hearing Aids (all types)

Yes Response

Select enhanced benefits:

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

Service Category Description **Benefit Description** 

Contrato Numero

Question

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
As there an enrollee Copayment?	No
s 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.

Contrato Número	American Borne in Junick school Most of the American	Approximate and the property of the property o	n veet and
	Response		Ouestion
The state of the s	A designation of the second of	Benefit Description	and the second s
M2 4 - 0 0 0 4		Service Category Description	
SEGUROS DE SALUD	s/Home Infusion Drugs	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	
ADMINISTRACION DE	manum camicanis amphilipha dadabayan kana ka dadaba kanada kanada kanada ka mataka da mataka j		A plant of the contract of the
	Response		Question
	A ANNI CANADA ANNI ANNI ANNI ANNI ANNI ANNI ANNI	Benefit Description	Company or the control of the contro
		Service Category Description	
	յs/Home Infusion Drugs	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	

19a Reduced Cost Sharing for VBID/ UF/SSBCI	23BC1
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 III?	No
Are you offering a VBID Hospice Benefit?	No
ne VBID Model? (VBID Part D Rewards and Incentives programs	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
dentify 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 borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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 ADMINISTRACION DE

EMI Contrato Número

№24-0004

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	

					ſ	N. Carrier					19b	PBP Section		A 2000 ST 71 1000		
				:							Additional Benefits for VBID/UF/SSBCI	Category	A. Carrier			3
Č	Is there a package level maximum coverage amount?	Are any benefits exempt from the plan-level deductible?	Select all the Non-Medicare-covered additional benefits offered in this package:	Is there a prerequisite for any additional benefits for this package?	Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	Does the enrollee need to have all diseases selected to qualify?	Expected Number of Enrollees to be engaged and receive Model benefits:	Expected Number of Enrollees to be Targeted:	Select LIS reduction level:	Targeting Methodology - Please choose one or both:	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	Question	Benefit Description	Service Category Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package
	NO SEGUROS DE SALUD	NO ADMINISTRACION DE	13i10: General Supports for Living; 13i1: 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	No	No	No	1139	1139	Dual-Eligible Status (for territories)	Socioeconomic Status	VBID	Response				kage 1

Mandatory	Select type of benefit for Pest Control:		
	Does the plan provide Pest Control as a supplemental Yes benefit under Part C?		1
Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.	Notes: Max		
	Is a referral required for Food and Produce?		
Σ.	Is authorization required?		
Chi	Is there an enrollee Copayment?		
( 111)	Is there an enrollee Deductible?		
	Is there an enrollee Coinsurance?		
Contrato Número	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?		
-	Select Maximum Plan Benefit Coverage periodicity:	Para Para Para Para Para Para Para Para	
	Indicate Maximum Plan Benefit Coverage amount: 210.00	72. 4	
	Is there a service-specific Maximum Plan Benefit Coverage Yes amount?		
ndatory ADMINISTRACION DA	Select type of benefit for Food and Produce:		100
	Does the plan provide Food and Produce as a supplemental Yes benefit under Part C?		No.
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 what type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes: Soc Sup	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	19b - 13i
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 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.	Notes:  A VI Proc nee dire. sup offe (8 v Gen Non Non		
Response	Question Res	Category	PBP Section
1	Benefit Description		
	Service Category Description		
	Disease States:		
<b>L</b>	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

	No	Is this benefit unlimited for number of trips for Any Location?		
vans, buses with hydraulic	Fleet includes sedans, minivans, buses with hydraulic ramps.	Description:		
2	Van; Medical Transport	Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	manu d	**********
Conuato Numero	One-way	Select Type of Transportation for Non-Medical Needs for Plan-approved Location:		
	Every year	Select Plan-approved Location Trips periodicity:	The same of the sa	
-	0	Indicate number of trips for Plan-approved Location:	1. T.	7
1024-000	No	Is this benefit unlimited for number of trips for Planapproved Location?		
SEGUROS DE SALU	Mandatory	Select type of benefit for Plan-approved Location:		
ADMINISTRACION DB	Plan-approved Location	Select enhanced benefit:		
	Yes	Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?		
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.	Member will choose up to two (2) services per quart visits annually) for pest control which is combined whome cleaning, any of the Home Assistance services in General Supports for Living, Hairstyling, and Pet Grooming. Additional Pest Control items are covered through the VBID Benefits Card.	Notes:		M
	No	Is a referral required for Pest Control?	MALAMATA PRANTICA S OR	Į.
	No	Is authorization required?		
	No	Is there an enrollee Copayment?		
÷	No	Is there an enrollee Deductible?	WAR THE	The same of the sa
	No	Is there an enrollee Coinsurance?	and the same of th	
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
	Response	Question	Category	PBP Section
	1) - 1) - 1) - 1) - 1) - 1) - 1) - 1) -	Benefit Description	tions of the	To the state of the state of
		Service Category Description		
		Disease States:		
	kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

	No Contrato Número	Is there a service-specific Maximum Enrollee Out-of-Pocket		-
	Every month	Select Maximum Plan Benefit Coverage periodicity:		
-40	0.00	Indicate Maximum Plan Benefit Coverage amount:	A SANSANIA	
- (	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
3C	Mandatory ADMINISTRACION DE	Select type of benefit for Indoor Air Quality Equipment and Services:		
	Yes	Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?		
	Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.	Notes:		
	No	Is a referral required for Transportation for Non-Medical Needs?	-	
	No	Is authorization required?	and the same of th	
	No	Is there an enrollee Copayment?	manager and the state of the st	
	No	Is there an enrollee Deductible?		
	No	Is there an enrollee Coinsurance?		A. C.
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
	Fleet includes sedans, minivans, buses with hydraulic ramps.	Description:		
	Van; Medical Transport	Select Mode of Transportation for Non-Medical Needs for Any Location:	and the same of th	
	One-way	Select Type of Transportation for Non-Medical Needs for Any Location:	The state of the s	
	Every year	Select Any Location Trips periodicity:	and department of the state of	
	0	Indicate number of trips for Any Location:		
	Response	Question	Category	PBP Section
		Benefit Description		
		Service Category Description		
		Disease States:		all and the second
	age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

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Cost?

Is there an enrollee Coinsurance?

No

Contrato Número			
#24-0004			
ADMINISTRACION DE SEGUROS DE SALLUD	Is a referral required for Social Needs Benefit?	14	
No	Is authorization required?	1	
No	Is there an enrollee Copayment?		
No	Is there an enrollee Deductible?	The state of the s	300
No	Is there an enrollee Coinsurance?		
t No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
Every month	Select Maximum Plan Benefit Coverage periodicity:		
0.00	Indicate Maximum Plan Benefit Coverage amount:		1
Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		A Partie
Mandatory	Select type of benefit for Social Needs Benefit:	of the state of th	
Yes	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.	Notes:		
No	Is a referral required for Indoor Air Quality Equipment and Services?		
No	Is authorization required?		
No	Is there an enrollee Copayment?		
No	Is there an enrollee Deductible?		
Response	Question	n Category	PBP Section
A PARTY CANADA C	Benefit Description	The state of the s	and a statement
	Service Category Description		
	Disease States:		
ckage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

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			and the second			ſ	The same of the sa						PBP Section			
		,		14.00			ė.						Category			
Notes:	Is a referral required for Complementary Therapies?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Complementary Therapies:	Does the plan provide Complementary Therapies as a supplemental benefit under Part C?	Notes:	Question	Service Category Description  Benefit Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1
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 prebiotic or probiotic products are also commonly used (NCCIM, 2016a).	No	No	No	No Contrato Número	No	1º24-000			Yes ADMINISTRACION DE	Mandatory	Yes	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.	Response	m		ckage 1

	To differ to tedanica.	
Contrato Número	Te authorization required?	
No	Is there an enrollee Copayment?	
No 1 2 4 - 0 0 0 4	Is there an enrollee Deductible?	
No C oil	Is there an enrollee Coinsurance?	
No SEGUROS DE SALUD	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
No ADMINISTRACIONI DE	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Mandatory	Select type of benefit for General Supports for Living:	A PARA LAND AND AND AND AND AND AND AND AND AND
Yes	Does the plan provide General Supports for Living as a supplemental benefit under Part C?	
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.	Notes:	
No	Is a referral required for Services Supporting Self- Direction?	16
No	Is authorization required?	The state of the s
No	Is there an enrollee Copayment?	
No	Is there an enrollee Deductible?	
No	Is there an enrollee Coinsurance?	
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Every month	Select Maximum Plan Benefit Coverage periodicity:	
0,00	Indicate Maximum Plan Benefit Coverage amount:	The state of the s
Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Mandatory	Select type of benefit for Services Supporting Self- Direction:	
Yes	Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?	
Response	Question	PBP Section Category
e	Benefit Description	
	Service Category Description	
	Disease States:	
age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	

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											13:			PBP Section				
						The state of the s					Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	•		Category				
Enter name of Service:	Notes:	Is a referral required for Other 1 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 1:	Enter name of Service:	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Notes:	Is a referral required for General Supports for Living?	Question	Benefit Description	Service Category Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Paci
Pet care	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.	No	No	No Y	No	No Communication Numero	No	No № 24 - 000	Mandatory Service Serv	Home cleaning SECURIO RACCION DE	Other 1; Other 2; Other 3; Other 4	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.	No	Response				ckage 1

No	Is a referral required for Other 3 Services?	T,	
	authorization req		
No	there		
No SEGUROS DE SAL	Is there an enrollee Consurance?  Is there an enrollee Deductible?		
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
Every month	Select Maximum Plan Benefit Coverage periodicity:		
0.00	Indicate Maximum Plan Benefit Coverage amount:	and the same of th	
ge Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Mandatory	Select type of benefit for Other 3:		
Memory Fitness and Cognitive Function	Enter name of Service:		
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.	Notes:		M
No	Is a referral required for Other 2 Services?	Alternation of the state of the	O department of the control of the c
No	Is authorization required?		
No	Is there an enrollee Copayment?	THE THE SAME ASSESS OF TRANSPORT BY THE TOTAL PARTY.	1
No	Is there an enrollee Deductible?		Top New II
No	Is there an enrollee Coinsurance?		
ket No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		an and
Every month	Select Maximum Plan Benefit Coverage periodicity:	It has my	
0,00	Indicate Maximum Plan Benefit Coverage amount:	The state of the s	
ge Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Response	Question	ion Category	PBP Section
A TO THE TOTAL PROPERTY OF THE TOTAL PROPERT	Benefit Description		7
	Service Category Description		enegad diserve
	Disease States:		gerente Face o
Package 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

### **PBP Section** Category Is a referral required for Other 4 Services? Is authorization required? Is there an enrollee Copayment? Is there an enrollee Deductible? Is there an enrollee Coinsurance? Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost? Is there a service-specific Maximum Plan Benefit Coverage amount? Select type of benefit for Other 4: Notes: Enter name of Service: Notes: Question 19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Service Category Description **Benefit Description** Disease States: 8 Member may choose up to two (2) services per quarter (8 visits annually) of hairstyling which is combined with pest 8 S No S N Hairstyling the VBID Benefits Card. instrument/meditation classes - will be covered through cooking/drawing/painting/language/musical Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, for Living, home cleaning, and pet grooming. control, home assistance services filed in General Supports Mandatory Response

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Contrato Número

## **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

Enfollee Type:
Part Colan Premium:
Part D Mart Premium: Special Needs Plan Type: Special Needs Plan: Part D Benefit: Status: Segment Geographic Name: Segment ID: Plan Geographic Name: Plan Name: Org, Marketing Name: Lead Marketing Region: formulary: Plan Type Region: Continuation Area Available: Visitor/Travel Benefit Available: \$0.00 Dual-Eligible Yes, Defined Standard Yes, 00024446 US - No Part A and Part B TMO OMT Version 2 - Renewal - Successfully exported to desk review (06/06/23) Region 2 MCS Classicare Platino Maximo (HMO D-SNP) MCS Classicare New York New York Puerto Rico

Standard Bid For Section B: Standard Bid For Section D: Standard Bid For Section C: Question 8 8 S Plan Level Data Response

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

Yes

Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE

SEGUROS DE SALUD

11/24-0004

Contrato Número

Dual-Eligible SNP:

Tiered Cost sharing for Part B Services	es	
	3.28 4 - 1.15 d	and the designment of the form
Question	Response	3
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services No 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?	
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
16 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

1b Inpatient Hospital-Psychiatric	₩24-000 A
Service Category Description	
Benefit Description	Contrato Número
THE CONTRACTOR CONTRAC	Response
s the plan provide Inpatient Ho	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Ou i

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.
And the state of t	

ion	An elif frame and a second and			
Response	Benefit Description	Service Category Description	1b Inpatient Hospital-Psychiatric	
	Response	Benefit Description Response	Service Category Description  Benefit Description  Response	1b Inpatient Hospital-Psychiatric  Service Category Description  Benefit Description  Response

2 Skilled Nursing Facility (SNF)		
Service Category Description  Benefit Description		1994
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	ADMINISTRACIONDE
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero	SEGUROS DE SALUD
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	№24-0004
Is there an enrollee Coinsurance?	No	
Is there an enrollee Copayment?	No	Contrato Número
What is your SNF benefit period?	Original Medicare	

SMR

2 Skilled Nursing Facility (SNF) Service Category Description	uF)
Benefit Description	
Question	Response
Do you charge cost sharing on the day of discharge?	
Is authorization required?	Yes
Is a referral required for SNF Services?	Yes
2 Skilled Nursing Facility (SNF)	WF)
Service Category Description	On
Benefit Description	transfer the dead of the property of the prope

Benefit Description	to de la decella de la papara, til a caractera de la papara de la papara de la caractera de la papara del papara de la papara del papara de la papara del papara del papara de la papara del p
Question	Response
3 Cardiac and Pulmonary Rehabilitation Services	Services
Service Category Description	
Benefit Description	
Question	Response
Dives 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 ADMINISTRACION DB
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	\$0.00 SEGUROS DE SALUD
Indicate Maximum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	\$0.00 10 2 4 - 0 0 0 4
Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00 Contrato Número
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00

3 Cardiac and Pulmonary Rehabilitation Services	Services
Service Category Description	
Benefit Description	
Question	
ce for se (PA	\$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.

1	Question				and perjoins and an	Is there an enrollee Copayment?
4b Urgently Needed Services	Response	Benefit Description	Service Category Description	4a Emergency Services	to a state and the control to secure he	No
№24-0004	SEGOTOS DE SALUD	ADMINISTRACION DE			into data . There descripts by problem part brought in Michigania	A CONTRACT OF THE CONTRACT OF

Response Contrato Número

Service Category Description

Benefit Description

Question

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

TO DESCRIPTION OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY	TI THE PROPERTY OF THE PARTY OF
4c Worldwide Emergency/Urgent Coverage	rage
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 ADMINISTRACION DE
Is there an enrollee Copayment?	No SECTION DE SALTIO
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	\$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	\$0.00 <b>10 2 4 -</b> 0 0 0 4
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 Contrato inimeto
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	lization
Service Category Description	escription
Benefit Description	ption
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	
Is authorization required?	No
Is a referral required for Partial Hospitalization?	No
Britansiya min yayana ya	A CONTRACTOR AND THE PROPERTY OF THE PROPERTY

Service Category Description	Description
Benefit Description	cription
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
To a referral required for Home Health Consider?	Yes

7a Primary Care Physician Services	ervices	
Service Category Description	ption	ADMINISTRACIONA
Benefit Description	6	SEGUROS DE ALTON DE
	3	
	N <sub>O</sub>	7 0 0 0 - 4 2 ml
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	Contrato Ni
Is there an enrollee Copayment?	No	Official

7b Chiropractic Services	
Service Category Description	ion
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	.S.	
Service Category Description		
Benefit Description	The second secon	The second secon
A THE TAXABLE AND	Response	ADMINISTRACION DB
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	Nº 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No	
Is authorization required?	Yes	Contrato Número
Is a referral required for Occupational Therapy Services?	No	

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7d Physician Specialist Services excluding Psychiatric Servic	ng Psychiatric Services
Service Category Description	iption
Benefit Description	
	Response
re a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
e?	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	vices
Service Category Description	<b>D</b>
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Ts, 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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№24-0004 SMR

Contrato Número

7f Podiatry Services	es
Service Category Description	cription
Benefit Description	0.7
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	onal Services
Service Category Description	ription
Question	Response
ዋ	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	100	1 0 0
Service Category Description	ion	
Benefit Description		ACTON DE
	Response	ADMINISTRACION ADMINISTRACION SALUD
Enro	No	ODUGENOW
Is there an enrollee Coinsurance?	No	4 000 - 7 CON
Is there an enrollee Deductible?	No	To C
	2	

Contrato Número

7h Psychiatric Services	ies
Service Category Description	ription
Question	Response
Is there an enrollee Copayment?	
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

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7i Physical Therapy and Speech-Language Pathology Services	Pathology Services	
Service Category Description	on	
Benefit Description	The first transport of	NAME AND ADDRESS OF THE PARTY O
Question	Response	of many trans
specific M	No	4
Is there an enrollee Coinsurance?	No	A DAG
Is there an enrollee Deductible?	No	SECTION DE SATURDE SATURDE
Is there an enrollee Copayment?	No	
Is authorization required?	Yes	题2 A - O O O A
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No	

7j Additional Telehealth Benefits	Contrato Número
Service Category Description	
Benefit Description	JWK 2
Question	Response
er 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

7j Additional Te	7j Additional Telehealth Benefits
Service Categ	Service Category Description
Benefit C	Benefit Description
Is there an enrollee Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Benefits?	No
or Additional Telek	No

7k Opioid Treatment Program Services	ices
Service Category Description	
Benefit Description	
Question	On the circles of the character of the c
ers a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Opioid Treatment Program Services?	No
	711.

8a Outpatient Diagnostic Procedures, Tests and Lab Services	ts and Lab Serv	/ices
Service Category Description	tion	
Benefit Description		
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	ADMINISTRACION DB
Is there an enrollee Coinsurance?	No	SEGUROS DE SALUD
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	# 2 4 - 0 0 0 4
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	Contrato Número
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	\$0.00	

8a Outpatient Diagnostic Procedures, Tests and Lab Services	d Lab Services
Service Category Description	
Benefit Description	
Question	Response
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	\$0.00
on the same day, does only the maximum	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological	ogical 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?	ADMINISTRACION DE
Is authorization required?	Yes SALUD
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes IIO O

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Contrato Número

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9a Outpatient Hospital Services	es
Service Category Description	3
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

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	Question	Benefit Description	Service Category Description	9a Outpatient Hospital Services
TOTAL CONTROL OF THE TOTAL CON	Response	The second secon	ption	rvices

9b Ambulatory Surgical Center (ASC) Services	ervices	THE COMMAND PROPERTY AND ADDRESS OF THE PARTY OF THE PART
Service Category Description		
Question	Response	ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	1 4 0 0 0 4
Is there an enrollee Copayment?	No	
Is authorization required?	Yes	Contrato Número
Is a referral required for Ambulatory Surgical Center Services?	Yes	

9c Outpatient Substance Abuse Services	ise Services
Service Category Description	ription
Benefit Description	5
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
Od Outpotiont Blood Continue	Angelon or person of the second secon

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tient	
Blood :	l
Serv	
Services	

Service Category Description

	AN THE TAX TO THE TAX
Question	Response
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	
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 ADASTATOTRACTOR DR

SEGUROS DE SALUD

10a Ambulance Services	
Service Category Description	חכ
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	iv.
Service Category Description	ion
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 ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SEGUROS DE SALUD
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No 10 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No

Contrato Número

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Service Category Description
Question
No
Is a referral required for Transportation Services?
Notes:  Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.

Notes:	Is authorization required?	Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	1s there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Question	Benefit Description	Service Category Description	11a Durable Medical Equipment (DME)
Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.	Yes	Yes	No	No	No	No	Response	A THE RESIDENCE OF THE PARTY OF	otion	nt (DME)

11b Prosthetics/Medical Supplies  Service Category Description	pplies tion	
Benefit Description	A TOTAL CONTRACTOR AND	
Question	Response	T. Delta
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	AD MINISTRACION DE
Is there an enrollee Copayment?	No	SEGUROS DE SALUD
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0.00	NO O
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0.00	# C 4 = U U U 4

11b Prosthetics/Medical Supplies	plies
Service Category Description	On
Benefit Description	
stion	Response
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
THE RESERVE AND THE PROPERTY OF THE PROPERTY O	Bergeral Communication of the state of the s

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes o	peutic 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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№24-0004

12 Dialysis Services	
Service Category Description	ption
	onse
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	
Is authorization required?	
Is a referral required for Dialysis Services?	No
	The second secon

13a Acupuncture	
Service Category Description	ion
Benefit Description	
Question	Response
Does the plan provide Acupuncture as a supplemental benefit under Part C?	
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Еvery 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 ADMINISTRACION DE
	CTOTAL OF THE COURT

SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

IWO	encered in this section.
2	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 continu
Response	Question
And the second of the second o	Benefit Description
3	Service Category Description
	13c Meal Benefit
	Does the plan provide Over-The-Counter (OTC) Items as a supplemental benefit under Part C?
Response	Question
A designate annual programme of the control of the	Benefit Description
5	Service Category Description
ems	13b Over-the-Counter (OTC) Items
Response	Question
	Benefit Description
3	Service Category Description
	13a Acupuncture

ADMINISTRACION DE SEGUROS DE SALUD Question

Service Category Description

13e Other 2

**Benefit Description** 

Response

Service Category Description

13d Other 1

**Benefit Description** 

Response

Question

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Response	Question Response
	Benefit Description
	Service Category Description
iervices	13g Dual Eligible SNPs with Highly Integrated Services
Response	Question
The state of the s	Benefit Description
	Service Category Description
	13f Other 3

Question 13i Non-Primarily Health Related Benefits for the Chronically III Service Category Description **Benefit Description** 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?	
Is a referral required?	No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Question

Is a referral required?

	Benefit Description
onse	
SEGURUS DE SALUD	ADMINISTRACION DE

Contrato Número

SWR

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

14c Other Defined Supplemental Repetits	Afte
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
Ts 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 ADMINISTRACIONAL
Indicate limit for number of sessions	6 SIGUROS DE SALILIA
Indicate the number of sessions periodicity:	Every year
	贈24-0004

14c Other Defined Supplemental Benefits	nefits	
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	ADMINISTRACION DE
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	\$0.00	SECONOR DE SALUD
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	\$0.00	2 /
Indicate Minimum Copayment amount for Fitness Benefit:	\$0.00	- 7 000 4
Indicate Maximum Copayment amount for Fitness Benefit:	\$0.00	
Indicate Minimum Copayment amount for Alternative Therapies:	\$0.00	Contrato Número
Indicate Maximum Copayment amount for Alternative Therapies:	\$0.00	1
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.	licensed dietitian exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.	. Member has access and a healthier
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.	t face-to-face visits pst common s. 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.	t face-to-face visits pst common s.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.	/ear and must be
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.	ysician or medical

SWR

14d Kidney Disease Education Services	cation Services
Service Category Description	Description
Benefit Description	ption
The state of the s	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services	e Services	- :
Service Category Description	2	
Benefit Description		
Question	Response	The Married Property of the Control
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No	· dec
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	4
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0,00	
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00	
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0.00	
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0.00	OD AV das s tos
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 SECTION DE	ACTON DR
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00 Exaction of State SALUD	COLLACA
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00	000
Is authorization required for Medicare-covered Glaucoma Screening?	No C	V V 4
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No	
Is authorization required for Medicare-covered Barium Enemas?	No Contrato Número	umero

SWR

14e Other Medicare-Covered Preventive Services	eventive Services	
Service Category Description	cription	
	On	
Question	Response	The state of the s
dic	No	G. T.
uthorization required for Medicare-covered EKG following Welcome	No	
Is a referral required for any Services?	No	

15 Medicare Part B Rx Drugs and Home Infusion Drugs	fusion 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.
	All and the state of the state
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
	A transfer of the second

ADMINISTRACION DE SEGUROS DE SALUD

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EM C Contrato Número

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	iodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial
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 ATMINISTRACION DO
Select type of benefit for Extractions:	Mandatory STC JROS DE CALLES
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory 12 2 4 - 0 0 0 4
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

Surgery, Other Services)  Benefit Description  Benefit Coverage arrount:  Indicate Is basimum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Plan Benefit Coverage arrount:  Is there a service-specific Maximum Enrolles Out-of-Pocket Cost?  Is there a service-specific Maximum Enrolles Out-of-Pocket Cost?  Is there a nerrolles Consumere?  Is there a nerrolles Consumere?  Is there a nerrolles Consumere?  Is there an enrolles Consumere?  Indicate Maximum Copayment arrount for Medicate-covered Benefits:  Indicate Maximum Copayment arrount for Restorative Services:  Indicate Maximum Copayment arrount for Endodontics:  Indica		No	Is a referral required for Comprehensive Dental Services?
Surgery, Other Services)  Service Category Description  Benefit Description  Response  Plan-specific Maximum Plan Benefit Coverage amount?  Plan-specified amount per period in the Maximum Plan Benefit Coverage amount:  Plan-specified amount per period in Plan-specified amount per p	SEGUROS DE SALUE	Yes	Is authorization required?
Surgery, Other Services)  Service Category Description  Benefit Description  Benefit Description  Benefit Coverage type:  Maximum Plan Benefit Coverage type:  Maximum Plan Benefit Coverage periodicity:  a service-specific Maximum Plan Benefit Coverage periodicity:  a service-specific Maximum Enrollee Out-of-Pocket Cost?  an enrollee Consurance?  an enrollee Copayment amount for Medicare-covered Benefits:  Minimum Copayment amount for Non-routine Services:  Maximum Copayment amount for Restorative Services:  Maximum Copayment amount for Restorative Services:  Minimum Copayment amount for Periodontics:  Minimum Copayment amount for Periodontics:  Minimum Copayment amount for Periodontics:  Maximum Copayment amount for Periodontics:  Minimum Copayment amount for Extractions:  Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other  Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other	ADMINISTRACION DE	\$0.00	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  nefits: nefits:		\$0.00	Minimum Copayment amount for Prosthodontics,
Surgery, Other Services)  Service Category Description  Benefit Description  st?  nefits: nefits:		\$0,00	Indicate Maximum Copayment amount for Extractions:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  st?  nefits: nefits:		\$0.00	Indicate Minimum Copayment amount for Extractions:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  st?  nefits: nefits:		\$0.00	Indicate Maximum Copayment amount for Periodontics:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  nefits: nefits:		\$0.00	Indicate Minimum Copayment amount for Periodontics:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  st?  nefits:		\$0.00	Indicate Maximum Copayment amount for Endodontics:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  nefits: nefits:	The state of the s	\$0,00	Indicate Minimum Copayment amount for Endodontics:
Surgery, Other Services)  Service Category Description  Benefit Description  st?  nefits:	-	\$0.00	Indicate Maximum Copayment amount for Restorative Services:
Surgery, Other Services)  Service Category Description  Benefit Description  unt?  st?  nefits:  nefits:		\$0.00	Indicate Minimum Copayment amount for Restorative Services:
Surgery, Other Services)  Service Category Description  Benefit Description  unt?  st?  nefits:		\$0.00	Indicate Maximum Copayment amount for Non-routine Services:
Surgery, Other Services) Service Category Description Benefit Description		\$0.00	Indicate Minimum Copayment amount for Non-routine Services:
Surgery, Other Services)  Service Category Description  Benefit Description  ange amount?  cket Cost?  Service Category Description  Coket Cost?		\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
Surgery, Other Services)  Service Category Description  Benefit Description  age amount?		\$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:
Surgery, Other Services)  Service Category Description  Benefit Description  rage amount?  cket Cost?		No	
Surgery, Other Services)  Service Category Description  Benefit Description  age amount?	The second of th	No	Is there an enrollee Deductible?
Surgery, Other Services)  Service Category Description  Benefit Description  rage amount?	Richard Strategy (P. )	No	
Surgery, Other Services)  Service Category Description  Benefit Description  rage amount?	4	Nò	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Surgery, Other Services)  Service Category Description  Benefit Description  Coverage amount?		Every year	Select the Maximum Plan Benefit Coverage periodicity:
Surgery, Other Services)  Service Category Description  Benefit Description  Coverage amount?		1000.00	Indicate Maximum Plan Benefit Coverage amount:
Surgery, Other Services)  Service Category Description  Benefit Description  Service-specific Maximum Plan Benefit Coverage amount?	nt per period	Plan-specified amoun	Select the Maximum Plan Benefit Coverage type:
Surgery, Other Services) Service Category Description Benefit Description	Transport of the Control of the Cont	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
Surgery, Other Services)  Service Category Description  Benefit Description		Response	Question
Surgery, Other Services)  Service Category Description	The state of the s	e decipe has	Benefit Description
Surgery, Other Services)		,	Service Category Description
			Surgery, Other Services)

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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:	L
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
Indivate 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 ADMINISTRACION DE
Is there an enrollee Deductible?	No SEGULOS DE SALUD
Is authorization required?	No In o
Is a referral required for Eye Exams?	No N

17b Eyewear	Contra	Contrato Número
Service Category Description		
	<b>V V</b>	
Question	Response	The second
e plan provide	Yes	
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames	nes); Eyeglass lenses;
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	

Benefit Description  Benefit Description  Response  Yes  Mandatory	
	The state of the s
Mandatory	
Yes	a managana, tamaganan
Mandatory	
Yes	
Yes	-
Plan-specified amount per period	per period
Yes	The second section is a second section of the second section s
600.00	Par man i
Every year	
No	ADMINISTRACION DE
No	SEGUROS DE SALUI
No	No o
No	12 4 - 0 0 0 4
\$0.00	The state of the s
\$0.00	Contrato Número
No	5410
No	CAUC
Eyewear benefit maxim benefit amount is comb Provider and/or membe plan benefit coverage a	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.
	Mandatory Yes Yes Yes Plan-specified amount Yes 600.00 Every year No No No No No No No No Provider and/or membe plan benefit coverage

	ion
stion	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
	The state of the s

18a Hearing Exams

18a Hearing Exams		
Service Category Description	n	
Benefit Description		
Question	Response	The same of the sa
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	A.S. Danie Browns I Tolkinger
Select Routine Hearing Exams periodicity:	Every year	The state of the s
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	111 112 112 1111 1111 1111 1111 1111 1111 1111 1111
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	
19 t/ere an enrollee Coinsurance?	No	
Is there an enrollee Copayment?	No	
Indicate Minimum Copayment amount for Medicare-covered Benefits:	\$0.00	THE PARTY NAME OF
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	ADMINISTRACION DE
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	\$0.00	SEGURCS DE SALUD
Is authorization required?	No	Lin D
Is a referral required for Hearing Exams?	No	1 2 4 - 0 0 0 4

Does the plan provide Hearing Aids as a supplemental benefit under Part C?  Yes  Select enhanced benefits:  Hearing Aids (all types)	sponse	Benefit Description	Service Category Description	18b Hearing Aids
--	--------	---------------------	------------------------------	------------------

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.

Question	And the state of t		Annual Community	Question			The Branch Addition of the Control o
	Benefit Description	Service Category Description	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs	Response	Benefit Description	Service Category Description	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs
	Contrato Número		電ン 4 - 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SEGUROS DE SALUID	ADMINISTR ACION DE		A many and a second sec

SMR

19a Reduced Cost Sharing for VBID/UF/SSBCI	/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 III?	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 No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No 0 0 - 4 - 0 0 0 4
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  Contrato Número
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 borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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

2 EMR

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)	<u> </u>

		19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	rage 1
		Disease States:	
		Service Category Description	
		Benefit Description	
PBP Section	Category	Question	- 1
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:	3026
		Expected Number of Enrollees to be engaged and receive Model benefits:	3026
6		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; 13i1: 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 ADMINISTRACION DE
		Is there a package level maximum coverage amount?	No SEGURGS DE SALUD

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Mandatory	Select type of benefit for Pest Control:		
Yes	Does the plan provide Pest Control as a supplemental benefit under Part C?	11.11	
Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.	Notes:	The form of the co	
No	is a referral required for Food and Produce?		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
No :	Is authorization required?	7.2.1	
No Y	Is there an enrollee Copayment?		
No Contrato Número	Is there an enrollee Deductible?		and many and the first state of the state of
No	Is there an enrollee Coinsurance?		
No № 2 4 - 0 0 0 4	Is there a service-specific Maximum Enrollee Out-of-Pocket   Cost?		
Every month SEGURUS DE SALUD	Select Maximum Plan Benefit Coverage periodicity:		
180.00 ADMINISTRACION DE	Indicate Maximum Plan Benefit Coverage amount:		
Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Mandatory	Select type of benefit for Food and Produce:		The state of the s
Yes	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 what type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	19b - 13i
A VBID Benefits Card can be used towards Food & Produce, indoor air quality equipment and services, social Produce, indoor air quality equipment and services, social Produce, 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.	Notes:		
Response	Question	Category	PBP Section
	Service category pescription  Benefit Description		The state of the s
	Disease States:		
age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

		***************************************			the second many of the second ma					N								PBP Section Category				
Is this benefit unlimited for number of trips for Any Location?	Description:	Select Mode of Transportation for Non-Medical Need for Plan-approved Location:	Select Type of Transportation for Non-Medical Needs for Plan-approved Location:	Select Plan-approved Location Trips periodicity:	Indicate number of trips for Plan-approved Location:	Is this benefit unlimited for number of trips for Planapproved Location?	Select type of benefit for Plan-approved Location:	Select enhanced benefit:	Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?	Notes:	Is a referral required for Pest Control?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Question	Benefit Description	Service Category Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1
No .	Fleet includes sedans, minivans, buses with hydraulic ramps.	Van; Medical Transport	One-way Contrato Número	Every year	0 24-0004	No SEGUROS DE SALUD	Mandatory ADMINISTRACION DB	Plan-approved Location	Yes	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.	No	No	No	No	No	et No	No	Response	The first time to the first time time time time time time time tim			ackage 1



	No	Is there an enrollee Coinsurance?		
Contrato Número	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		10 20 20 20 20 20 20 20 20 20 20 20 20 20
1 4	Every month	Select Maximum Plan Benefit Coverage periodicity:		
000 4 - 000 4	0.00	Indicate Maximum Plan Benefit Coverage amount:		
SEGUROS DE SALUD	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?	7.00	180
ADMINISTRACION DE	Mandatory	Select type of benefit for Indoor Air Quality Equipment and Services:		
	Yes	Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?		
Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.	Transportation pro trips are a combina and 13i4 - Transpo	Notes:		
	No	Is a referral required for Transportation for Non-Medical Needs?		
The state of the s	No	Is authorization required?	And distance of the same of th	
	No	Is there an enrollee Copayment?		
	No	Is there an enrollee Deductible?		The same of the sa
	No	Is there an enrollee Coinsurance?		The same of the sa
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Fleet includes sedans, minivans, buses with hydraulic ramps.	Fleet includes seda ramps.	Description:		
sport	Van; Medical Transport	Select Mode of Transportation for Non-Medical Needs for Any Location:		
The state of the s	One-way	Select Type of Transportation for Non-Medical Needs for Any Location:		
j.	Every year	Select Any Location Trips periodicity:		:
	0	Indicate number of trips for Any Location:		
	Response	Question	Category	PBP Section
***************************************	Anna Continuos o Continuos o Organistas de Continuos de Continuo de Cont	Benefit Description	C	The case of the ca
		Service Category Description		
		Disease States:		
	kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

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		190 Additional benefits for VB1D/OF/SSBC1 - VB1D Fackage 1	age F
		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
	di	Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
The same of the sa		Indicate Maximum Plan Benefit Coverage amount:	0.00
A STATE OF THE PARTY OF THE PAR		Select Maximum Plan Benefit Coverage periodicity:	Every month
ſ		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
The second was produced to the second	To find the stands have been	Is authorization required?	No .
	į	Is a referral required for Social Needs Benefit?	No

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W24-0004

ADMINISTRACION DB SEGUROS DE SALUD

Contrato Número

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## **PBP Section** Category Indicate Maximum Plan Benefit Coverage amount: Is there an enrollee Copayment? Cost? Select Maximum Plan Benefit Coverage periodicity: Is there a service-specific Maximum Plan Benefit Coverage Does the plan provide Complementary Therapies as a supplemental benefit under Part C? Is a referral required for Complementary Therapies? Is authorization required? Is there an enrollee Deductible? Is there an enrollee Coinsurance? Select type of benefit for Complementary Therapies: Is there a service-specific Maximum Enrollee Out-of-Pocket Question 19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Service Category Description **Benefit Description** Disease States: 0.00 Yes herbs, dietary supplements, and prebiotic or probiotic products are also commonly used (NCCIM, 2016a). 8 8 8 8 Mandatory and include access to community or plan sponsored events include mind and body interventions such as meditation, chronic pain. Common complementary health approaches integrative medicine, which includes health approaches Benefits Card. They are increasingly referred to as Complementary therapies are covered through the VBID 8 Every month events/activities. concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to cognitive function - Club memberships, park passes, improve emotional and/or cognitive function, social Social Needs are covered through the VBID Benefits Card acupuncture. A variety of natural products, including spinal manipulation, yoga, massage, tai chi, and used to manage symptoms associated with acute and support attendance to all aforementioned musical events, counseling. This includes passes to to address social needs, events that address isolation and Response ADMINISTRACION DE SEGUROS DE SALUD Contrato Número

	No	Is authorization required?		
	No	Is there an enrollee Copayment?		t
Contrato Número	No	Is there an enrollee Deductible?		
	No	Is there an enrollee Coinsurance?		
№24-0004	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
SEGUROS DE SALUD	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
A NATIVITATION DE	Mandatory	Select type of benefit for General Supports for Living:	and another sector rises a sixty	
	Yes	Does the plan provide General Supports for Living as a supplemental benefit under Part C?		
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.	Services : VBID Bene language, continued	Notes:		1
To a	No	Is a referral required for Services Supporting Self- Direction?	program over the control of the cont	0
	No	Is authorization required?		The state of the s
as managed as a managed at a second at	No	Is there an enrollee Copayment?		
A COLUMN TO THE	No	Is there an enrollee Deductible?	1. Non-Admits	
	No	Is there an enrollee Coinsurance?		
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
nth	Every month	Select Maximum Plan Benefit Coverage periodicity:	i.	¥ra.
and the state of t	0.00	Indicate Maximum Plan Benefit Coverage amount:		
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
У	Mandatory	Select type of benefit for Services Supporting Self- Direction:		
	Yes	Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?		
O	Response	Question	Category	PBP Section
		Benefit Description		
anis wealon		Service Category Description		
		Disease States:		
	kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

2m2

Mandatory	Select type of benefit for Other 2:		
Pet care	Enter name of Service:		
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.	Notes:		
No	Is a referral required for Other 1 Services?	and the second s	
No	Is authorization required?		
No Contrato Número	Is there an enrollee Copayment?		
No	Is there an enrollee Deductible?		
No III C 4 II C C	Is there an enrollee Coinsurance?		
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	P TOTAL	
ADMINISTRACION DE SALITA	Is there a service-specific Maximum Plan Benefit Coverage amount?	The later was a few later	N
Mandatory	Select type of benefit for Other 1:	To the second se	
Home cleaning	Enter name of Service:		
Other 1; Other 2; Other 3; Other 4	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	19b - 13i
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.	Notes:		
No	Is a referral required for General Supports for Living?		
Response	Question	Category	PBP Section
	Service Category Description  Benefit Description		
	Disease States:		
ackage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

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	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 No Cost?	No
	Is there an enrollee Coinsurance?	No
	Is there an enrollee Deductible?	No
. com . m	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.
3	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 ADMINISTRACION DE
	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SEGUROS DE SALUD
	Is there an enrollee Coinsurance?	No 24-0004
	Is there an enrollee Deductible?	No
	Is there an enrollee Copayment?	No Contrato Número
	Is authorization required?	No
	Is a referral required for Other 3 Services?	No
		Sur

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		190 Additional Benefits for VB1D/UF/SSBC1 - VB1D Package Disease States:	age I
		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 No Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
1		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 4 Services?	No
Transcer.		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 SEGUROS DE SALUD

№24-0004

## **Bid Reports 2024**

## PBP Benefits Report

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

Part C Plan Premium: Part D Plan Premium: Enrollee Type: Segment Geographic Name: Segment ID: Plan Geographic Name: Org. Marketing Name: Plan Type: Plan Name: Lead Marketing Region: Continuation Area Available: Region: Isibor/Travel Benefit Available: Yes, 00024446 \$0,00 Part A and Part B OMI MCS Classicare on - Sn 8 N/A Version 2 - Renewal - Successfully exported to desk review (06/06/23) Region 3 MCS Classicare Platino Maximo (HMO D-SNP) Puerto Rico New York New York

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

Dual-Eligible SNP: Special Needs Plan Type: Special Needs Plan:

Medicare non-zero dollar cost sharing plan

Yes

Dual-Eligible

Yes, Defined Standard

Part © Benefit: Formulary:

	Response	Question
JWZ	Plan Level Data	
	No	Standard Bid For Section D:
	No	Standard Bid For Section C:
Contrato Número	No	Standard Bid For Section B;
	Yes	Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?

Tiered Cost sharing for Part B Services	ces
Question	Response
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services No 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
s authorization required?	Yes
Is a referral required for Inpatient Hospital-Acute Services?	Yes

Question	Companies - In-possible Williams of Paper (the Companies of The Companies of The Companies of Co		
	The same of the sa		
	Benefit Description	Service	
Resi	Benefit Description	Service Category Description	1a Inpatient Hospital-Acute
onse			
	de special free date of the cut between the cut		

Contrato Número	
	Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C? No
where the state of	Question
Nº 2 4 - 0 0 0 4	Benefit Description
	Service Category Description
SEGUROS DE SALUD	to milaticity to block the state of the stat
ALL MOTOWN LOTALITATORS	

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1b Inpatient Hospital-Psychiatric	2
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 No care?	
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.

	Question	TYPEDIA THE BRANCH		
	The state of the s	Privates in Basel. Private Vision Company Comp		
		. All and indicated the state of the state o		
The state of the s	e depuis	er de en		1b
The second section is a six manager and second section and second	The second distance of the second sec	Benefit Description	Service Category Description	1b Inpatient Hospital-Psychiatric
the result of the second of th	Response	Benefit Description	Description	l-Psychiatric
	Assessment A.			
	Assessing Stages and the set of the Part of Repairs return the Re-	The state of the s		
		The same of the sa		

2 Skilled Nursing Facility (SNF)		2011
Service Category Description		
Benefit Description	The state of the s	COLUMN TO SERVICE ASSOCIATION OF THE PARTY O
Question	Response	Common charles of the control of the
		N
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?	ADMINISTRACION DE	RACION DE
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	SEGUROS DE SALUL	DE SALUD
Is there an enrollee Coinsurance?	No N	0004
Is there an enrollee Copayment?	No	
What is your SNF benefit period?	Original Medicare Contrato	Contrato Número
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2 Skilled Nursing Facility (SNF)	
Service Category Description	
	Response
haring on the day of discharge?	No
ion required?	Yes
Is a referral required for SNF Services?	Yes

	Question	THE RESIDENCE OF THE PARTY OF T		
3 Cardiac and Pulmonary Rehabilitation Services	Response	Benefit Description	Service Category Description	2 Skilled Nursing Facility (SNF)
	15e	and the same of th		

	Service Category Description  Benefit Description	
	Question	Response
1	Does the plan provide Cardiac and Pulmonary Rehabilitation Services as a supplemental benefit under Part C?	No
C. A.	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
100	Is there an enrollee Coinsurance?	No
0	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
	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 ADMINISTRACION DE SECUROS DE SALUD
	Indicate Minimum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00 No 2 4 - 0 0 0 4
	Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation	\$0.00
	OCI VICES.	Contrato Número

Contrato Número

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3 Cardiac and Pulmonary Rehabilitation Services	Services
Service Category Description	
estion	
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	
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 Pulmon	3 Cardiac and Pulmonary Rehabilitation Services
Service Cat	Service Category Description
	Benefit Description
Question	Response
4a Emerg	4a Emergency Services
Service Cat	Service Category Description
	Benefit Description
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No

	Question	and a characteristic control for a control for a control for a control for the control for the control for a contr		6
4h Ilmentiv Needed Services	Response	Benefit Description	Service Category Description	4a Emergency Services
	7 0 0 0 - 7 6 m	SEGUROS DE SALUD	ADMINISTRACION DE	

Service Category Description

Benefit Description

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Contrato Número

Response

Question

Ac Worldwide Emergency / Irrent Coverage	Is there an enrollee Copayment?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Question	Benefit Description	Service Category Description	4b Urgently Needed Services
Ar Worldwide Emergency / Hrgent Coverage	No		3	Response	Benefit Description	Service Category Description	TO A MONTH INCOME TO I BELLE

4c Worldwide Emergency/Urgent Coverage	rage
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
	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.

ADMINISTRACION DE SEGUROS DE SALUD

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

6 Home Health Services	rvices	
Service Category Description	scription	
	tion	the state of the s
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	
~	No	
1s authorization required?	Yes	
Is a referral required for Home Health Services?	Yes	

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Primary
Care
Physic
ian Se
rvices

Service Category Description

Question	Response	CONTRACTOR AND
Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	ADMINISTRACION DE
Is there an enrollee Deductible?	No	SEGUKUS DE SALOR
Is there an enrollee Copayment?	No	MO 0 - 0 0 0 6

7b Chiropractic Services	98
Service Category Description	stion
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:	Еvery 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 Occupation	7c Occupational Therapy Services	
Service Cate	Service Category Description	
	Benefit Description	
Question	Response	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	A DATE TO A CION DE
Is there an enrollee Coinsurance?	No	SEGUROS DE SALUD
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	M2 4 - 0 0 0 4
Is authorization required?	Yes	100
rvices?	No	Contrato Número

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7d Physician Specialist Services excluding Psychiatric Services	cluding Psychiatric Services
Service Category Description	Description
	ption
	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
	No
Is there an enrollee Deductible?	
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Physician Specialist Services?	Yes

7e Mental Health Specialty Services	y Services
Service Category Description	ription
Benefit Description	חנ
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.

	Response	Question
№24-0004	Benefit Description № 2 4 - 0	Anis and the second of the sec
	Service Category Description	
SECTION DE CALLES	7f Podiatry Services	

7f Podiatry Services	ces
Service Category Description	cription
Benefit Description	Ön
Question	Response
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	
Is there a service-specific Maximum 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	sional Services
Service Category Description	scription
Question	Response
Enrollee Out-of-Pocket Cost?	
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

Contrato Mantelo		
Contrata Vikman	No	Is there an enrollee Deductible?
The state of the s	No	Is there an enrollee Coinsurance?
Nº 2 4 - 0 0 0 4		Enrollee Out-of-Pocket Cost?
	Response	Question
SECUROS DE SALUD	The state of the s	Benefit Description
ADMINISTRACION DE	tion	Service Category Description
	S	7h Psychiatric Services

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7h Psychiatric Services	ces
Service Category Description	ription
Benefit Description	On the second parameter of the second
Question	Response
	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

Service Category Description	iption	
Benefit Description	1	2 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
	Response	d gardy. The transfer with a distance of the same of t
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	ADMINISTRACION DE
Is there an enrollee Copayment?	No	SEGUROS DE SALUD
Is authorization required?	Yes	
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No	■ 2 4 = 0 0 0 4

7j Additional Telehealth Benefits	Contrato Nisman
Service Category Description	
Benefit Description	NW Y
Question	Response
er an Additional Telehea	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

7j Additional Telehealth Benefits	t i
Service Category Description	
Benefit Description	
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
a referral rec	
Manageria restriction department and the description of the Company of the Compan	

Total material	
7k Opioid Treatment Program Services	vices
Service Category Description	•
Be	
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?	
Is a referral required for Opioid Treatment Program Services?	No
	garb our can compare the compa

8a Outpatient Diagnostic Procedures, Tests and Lab Services	and Lab Services	100
Service Category Description	3	
Benefit Description		
Question	Response	ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	SEGONOS DE SONOD
Is there an enrollee Coinsurance?	No	NO 0 A - 0 0 0 A
Is there an enrollee Deductible?	No	1 000
Is there an enrollee Copayment?	No	
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	\$0.00	Contrato Número
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 Service	Lab Services
Service Category Description	
	to the second se
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	
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 Servic	ogical Services

8b Outpatient Diagnostic and Therapeutic Radiological Serv	ological 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 o	
Is there an enrollee Copayment?	No	
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (a.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	ADMINISTRACION DE
Is authorization required?	Yes	SEGUROS DE SALUD
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes	5

9a Outpatient Hospital Services	S
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

Application of the property of	
Response	Question
Benefit Description	Appear
Service Category Description	
9a Outpatient Hospital Services	

9b Ambulatory Surgical Center (ASC) Services	Services	
Service Category Description	5	ADMINISTRACION DE
Benefit Description		SEGUROS DE SALUD
Question	Response	160
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	1 000 - 4 Z
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	Contrato Número
Is there an enrollee Copayment?	No	
Is authorization required?	Yes	
Is a referral required for Ambulatory Surgical Center Services?	Yes	JAY Y

9c Outpatient Substance Abuse Services	use Services	
Service Category Description	ription	
		The state of the s
Question	Response	
5		2
Is there an enrollee Coinsurance?		
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	- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:		TO THE STATE OF TH
Is authorization required?	No	
Is a referral required for Outpatient Substance Abuse?	No	

		The same same the same same the same same same same same same same sam
9d Outpatient Blood Services	es	
Service Category Description	on	***
	ì	
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	ADMINISTRACION DE
Is there an enrollee Deductible?	No	SEGUROS DE SALUD
Is there an enrollee Copayment?	No	
Is authorization required?	No	1024-0004
Is a referral required for Outpatient Blood Services?	No	1

10a Ambulance Services	
Service Category Description	on
Question	Response
	No
Is there an enrollee Coinsurance?	
Is there an enrollee Deductible?	
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	
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:	
Is authorization required for non-emergency Medicare services?	Yes

224-0004	Is there an enrollee Copayment?
	Is there an enrollee Deductible?
SEGUROS DE SALUD	Is there an enrollee Coinsurance?
BUNOIDVALSIINIVUIV	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Is there a service-specific Maximum Plan Benefit Coverage amount?
Fleet includes sedans, minivans, buses with hydraulic ramps.	Description:
Medical Transport; Other, Describe	Select Mode of Transportation for Plan Approved Health-related Location:
One-way	Select Type of Transportation for Plan Approved Health-related Location:
Every year	Select Plan Approved Health-related Location Trips periodicity:
The state of the s	Indicate number of trips for Plan Approved Health-related Location:
O THE AREA	As this benefit unlimited for number of trips for Plan Approved Health-related Location?
Mandatory	Select type of benefit for Plan Approved Health-related Location:
Plan Approved Health-related Location	Select enhanced benefit:
	Does the plan provide Transportation Services as a supplemental benefit under Part C?
Response	Question
4.71	Benefit Description
	Service Category Description
	10b Transportation Services
· ·	The state of the s

10b Transportation Services	
Service Category Description	
Benefit Description	
	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 HRNs, and 13i4 - Transportation for Non-Medical Needs.
10 cm (10)	

11a Durable Medical Equipment (DME) Service Category Description	DME)
Benefit Description	
	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
rization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
	AND TO A STATE OF THE STATE OF

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		Medical	
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# Service Category Description

	Response	* 1
	No	TOTAL CACION DE
Is there an enrollee Coinsurance?		OF STATE SALUD
Is there an enrollee Deductible?	No	1024 000,
Is there an enrollee Copayment?	No	4000
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0.00	
Indicate Maximum Consyment amount per Hem for Medicare-covered Prosthetic Devices:	\$0.00	Contrato Número

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

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	\$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	tion
Benefit Description	And the second s
	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?	
Is a referral required for Dialysis Services?	No

13a Acupuncture	
Service Category Description	tion
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 ADMINISTRACION DE
	CHILD TO THE CALLED

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Service Category Description  Benefit Description  Benefit Description  Response  13b Over-the-Counter (OTC) Items  Service Category Description  Perponse  Service Category Description  Service Category Description  Benefit Description  Response  Ouestion  Response	AND THE CONTRACTOR COMMENTS.	12c Most Ranafit
Service Category Description  Benefit Description  Response  13b Over-the-Counter (OTC) Items  Service Category Description  Benefit Description  Response		
Service Category Description  Benefit Description    Response	Build Build and a season of the season of th	THE THE PARTY OF T
Service Category Description  Benefit Description  Response  13b Over-the-Counter (OTC) Items  Service Category Description	5	Benefit Description
Service Category Description  Benefit Description  Response		Service Category Description
13a Acupuncture  Service Category Description  Benefit Description  Response	The second secon	13b Over-the-Counter (OTC) Items
13a Acupuncture Service Category Description Benefit Description		
13a Acupuncture Service Category Description	A SECTION AS A SECTION AS	And the second s
13a Acupuncture		Service Category Description
		13a Acupuncture

13c Meal Benefit	
Service Category Description	
Benefit Description	
Control description of management can be not proved by the control of the control	Respo
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
***	The state of the s

Service Category Description	13e Other 2		Response	Benefit Description	Service Category Description
iption		The second secon	Response	The same of the sa	iption

**Benefit Description** 

Response

Question

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ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

Question			TOTAL TO A TAXABLE	Question	i c		in the common ways of the common	desides to the best of the second sec	Question	The distribution of the control of the control of the description of the description of the distribution o		
	Benefit Description	Service Category Description	13i Non-Primarily Health Related Benefits for the Chronically		Benefit Description	Service Category Description	13g Dual Eligible SNPs with Highly Integrated Services	Patrick.		Benefit Description	Service Category Description	13f Other 3
Response			he Chronically III	Response	and the same of the same and th		ed Services	ntinom	Response	a placetone de		

14a Medicare-covered Zero Cost-Sharing Preventive Service	Preventive Services
Service Category Description	tion
Benefit Description	
	i de la desta de la composito dela composito de la composito de la composito de la composito d
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
	No
Is a referral required?	No

14a Medicare-covered Zero Cost-Sharing Preventive Services

Service Category Description

Benefit Description

Question

Response

ADMINISTRACION DE SEGUROS DE SALUD

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

14c Other Defined Supplemental Benefits	efits
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 ADMINISTRACION DE
Indicate limit for number of sessions	6 SEGUROS DE SALOD
Indicate the number of sessions periodicity:	Every year 10 2 4 0 0 0 4

14c Other Defined Supplemental Benefits	enefits
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 ADMINISTRACION DE
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	\$0.00 SEGUNUS DE SALUD
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 Contrato Número
Indicate Maximum Copayment amount for Alternative Therapies:	\$0.00
is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Mutritional/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.

14d Kidney Disease Education Services	ces
Service Category Description	
Benefit Description	
ere e e e e e e e e e e e e e e e e e e	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
	No
Is authorization required?	
Is a referral required for Kidney Disease Education Services?	

Contrato Número	No	Is authorization required for Medicare-covered Barium Enemas?
	No	Is authorization required for Medicare-covered Diabetes Self-Management Training?
\$ 000 cd	No	Is authorization required for Medicare-covered Glaucoma Screening?
7 0 0 0 7 0 01	\$0.00	Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:
SEGUROS DE SALUD	\$0.00	Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:
A JAMES LACION DE	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:
The state of the s	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:
CANADATANAN CANADA	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:
	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:
	No	As there an enrollee Copayment?
COMMITTEE TO A SECTION TO THE PARTY OF THE P	No	Is there an enrollee Deductible?
The second secon	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?
to Clark Improve them assessment from the Control	Response	Question
ALL LANGE	* and a second	Benefit Description
	Š	Service Category Description
	ve Services	14e Other Medicare-Covered Preventive Services

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Service Category Description	escription	
Benefit Description	ption	. 4 447
Question		7 77 77 87 87 87 87 87 87 87 87 87 87 87
Is authorization required for Medicare-covered Digital Rectal Exams?	No	
Is authorization required for Medicare-covered EKG following Welcome Visit?	No	COLD PO
Is a referral required for any Services?	No	

15 Medicare Part B Rx Drugs and Home Infusion Drugs	fusion Drugs
Service Category Description	
Benefit Description	
Question	Response
Attestation:	blee cost sharing for a Part coinsurance amount of the clary coinsurance for that active coinsurance percent rollee cost sharing off of the 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 SEGUROS DE SALUI.

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Contrato Número

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n provide Preventive De	Question	Benefit Description	Service Category Description	To rieventive being Services (viai Exams, riophylaxis (creaming), i morine i realinent, being A-mys)
	a de la composición del composición de la composición de la composición de la composición del composición de la composic	And some depended.	- 5000	(ckm

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	odontics, Extractions, Prosthodontics, Other Oral/Maxillofacial
Service Category Description	2
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:	
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 ADMINISTRACTOR DE
Is this benefit unlimited for Periodontics?	Yes SEGUNUS DE SEDUD
Select type of benefit for Extractions:	Mandatory 10 5
Is this benefit unlimited for Extractions?	Yes The Control of th
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 Contrato Número

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Service Satisfact Pass   Service Satisfact P	16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services)	riodontics, Extractions, Prosthodon	ntics, Other Oral/Maxillofacial
Response         Yes         Plan-specified amount per period         1000.00         Every year         No         No         No         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00         \$0.00	Service Category Description	n	80.0
Response           Yes           Plan-specified amount per period           1000.00           Every year           No           No           No           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00           \$0.00	Benefit Description		
Yes Plan-specified amount per period 1000.00 Every year No No No \$0.00	Question	Response	
Plan-specified amount per period 1000.00  Every year  No  No  No  \$0.00	Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes	200
1000.00  Every year  No  No  No  \$0.00	Select the Maximum Plan Benefit Coverage type:		
Every year  No  No  No  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00  \$0.00	Indicate Maximum Plan Benefit Coverage amount:	1000.00	
No No No No \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Select the Maximum Plan Benefit Coverage periodicity:	Every year	5
No No No No \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	there	No	
No No No \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	there	No	
No \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	there	No	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Is there an enrollee Copayment?	No	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Minimum Copayment amount for Non-routine Services:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00		\$0.00	The second secon
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Minimum Copayment amount for Restorative Services:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Maximum Copayment amount for Restorative Services:	\$0,00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 No	Indicate Minimum Copayment amount for Endodontics:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Maximum Copayment amount for Endodontics:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00 \$0.00	Indicate Minimum Copayment amount for Periodontics:	\$0.00	
\$0.00 \$0.00 \$0.00 \$0.00	Indicate Maximum Copayment amount for Periodontics:	\$0.00	The special is to be a second of the second
\$0.00 \$0.00 \$0.00 No	Indicate Minimum Copayment amount for Extractions:	\$0.00	B THE RELIGION AND ADDRESS OF THE PARTY OF T
\$0.00 \$0.00 Yes	Maximum Copayment amount for	\$0.00	-American
\$0.00 Yes	Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	\$0.00	NOIDVALSINIMGY
Omprehensive Dental Services? No Yes 19 2	Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	\$0.00	SEGUROS DE SALU
a referral required for Comprehensive Dental Services?	Is authorization required?	Yes	1024-000
	۵	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
Indicate number of exams for Routine Eye Exams:	
Select the Routine Eye Exams periodicity:	Еvery 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 ADMINISTRACION
Is there an enrollee Deductible?	No SEGUROS DE SALU
As authorization required?	No
Is a referral required for Eye Exams?	No 112 2 4 - 0 0 0
17b Eyewear	Contrata
Service Category Description	Contato Numero

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

Select type of benefit for Contact lenses:
Is this benefit unlimited for Contact lenses?

Yes

Mandatory

Mandatory

Select enhanced benefits:

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

**Benefit Description** 

Yes

Response

Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames

Question

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.	Eyewear benefit maximum amount inclubenefit amount is combined with a hear Provider and/or member must verify remplan benefit coverage amount available.	Notes:
237	No	is a referral required for Eyewear?
C WIN S	No	Is authorization required?
Contrato Número	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Benefits:
№24-000 4	No	Is there an enrollee Copayment?
	No	Is there an enrollee Deductible?
SEGUROS DE SALUD	No	Is there an enrollee Coinsurance?
ADMINISTR CON DE	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Every year	Select the Combined Maximum Plan Benefit Coverage periodicity:
	600.00	Indicate Combined Maximum Plan Benefit Coverage amount:
And the second of the second o	Yes	Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?
riod	Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
	Yes	Is this benefit unlimited for Eyeglass frames?
ALCOHOL TO THE PARTY OF THE PAR	Mandatory	Select type of benefit for Eyeglass frames:
The same separate	Yes	Is this benefit unlimited for Eyeglass lenses?
	Mandatory	Select type of benefit for Eyeglass lenses:
	Yes	Is this benefit unlimited for Eyeglasses (lenses and frames)?
The parties	Response	Question
	ion	Benefit Description
	cription	Service Category Description
_		17b Eyewear

18a Hearing Exams	
Service Category Description	tion
Question	of the state of th
xams as a supplemental benefit	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
	Y

	Hearing Aids (all types)	Select enhanced benefits:
	Yes	Does the plan provide Hearing Aids as a supplemental benefit under Part C?
	Response	Question
The state of the s	The same of the sa	Benefit Description
	3	Service Category Description
		18b Hearing Aids
1145	No	Is a referral required for Hearing Exams?
es e majorio como e e e e e e e e e e e e e e e e e e	No	Is authorization required?
Contrato Número	\$0,00	indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:
	\$0.00	Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:
かりのこちと記	\$0.00	Indicate Maximum Copayment amount for Routine Hearing Exams:
	\$0.00	Indicate Minimum Copayment amount for Routine Hearing Exams:
SEGUROS DE SALUD	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Benefits:
ADMINISTRACION DE	\$0.00	Indicate Minipulm Copayment amount for Medicare-covered Benefits:
	No	Is there an enrollee Copayment?
,	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	No	Is there an enrollee Deductible?
A CONTRACT OF STATE O	No	Is there a service-specific Maximum Plan Benefit Coverage amount?
The second secon	Every year	Select Fitting/Evaluation for Hearing Aid periodicity:
Company of the Compan	<b>L</b>	Indicate number for Fitting/Evaluation for Hearing Aid:
	No, indicate number	Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?
	Mandatory	Select type of benefit for Fitting/Evaluation for Hearing Aid:
The Company of the Co	Every year	Select Routine Hearing Exams periodicity:
The state of the s	The second secon	Indicate number for Routine Hearing Exarrs:
	No, indicate number	Is this benefit unlimited for Routine Hearing Exams?
	Mandatory	Select type of benefit for Routine Hearing Exams:
The state of the s	Response	Question
	maka. II. Im Mayara windan.	Benefit Description
	3	Service Category Description
		18a Hearing Exams

Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount	Benefit and Maximum Plan Covrepair of devices. This benefit maximum amount.	Wotes:
	Yes	Is a referral required for Hearing Aids?
Contrato Número	Yes	Is authorization required?
	. No	Does your plan cover OTC hearing aids as part of your hearing aid benefit?
M2 4 - 0 0 0 4	No	Is there an enrollee Deductible?
The second secon	No	Is there an enrollee Copayment?
The state of	No	Is there an enrollee Coinsurance?
ADMINISTRACION DE	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Company on the state of the sta	Every year	Indicate Maximum Plan Benefit Coverage periodicity:
The second secon	600.00	Indicate Maximum Plan Benefit Coverage amount:
riod	Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
	Both ears combined	Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
	Every year	Select Hearing Aids (all types) periodicity:
The state of the s	2	Indicate quantity for Hearing Aids (all types):
	No, indicate number	Is this benefit unlimited for Hearing Aids (all types)?
	Mandatory	Select type of benefit for Hearing Aids (all types):
The Transport of The transport	Response	Question
	· Personal Confession of the C	Benefit Description
	ion	Service Category Description
		18b Hearing Aids

Response	Benefit Description	Service Category Description	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs
sponse	W 100 AU	Jul Quit	

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

Response

Question

	33001
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 III?	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 SEGUROS DE SA LOS
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No 1924 0 0 0
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 Contrato Número
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
Ideptify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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

TO William beliefly of Appril of App	Control of the contro	posts and an area of the same	Queeds as Administration 1.1.1
	Response	and the state of t	Paradicipa and report there e
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No		· Pr
How many packages do your Additional Benefits contain? (1-15)	Ľ	The state of the s	

		19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1  Disease States:	kage 1
		Service Category Description	
		Benefit Description	
PBP Section	Category	Question	Response
196	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 ADMINISTRACION DE
100		Expected Number of Enrollees to be engaged and receive Model benefits:	5168 SEGUROS DE SALUD
destr	(a) a design and a second and a second	Does the enrollee need to have all diseases selected to qualify?	No №24-0004
H		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No Contrato Número
		Is there a prerequisite for any additional benefits for this package?	NO SMR
		Select all the Non-Medicare-covered additional benefits offered in this package:	13i10: General Supports for Living; 13i1: 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

effit Coverage amount:  effit Coverage periodicity:  c Maximum Enrollee Out-of-Pocket urrance?  ctible?  yment?  yment?  No  No  No  No  Aximum Plan Benefit Coverage Card carries forward to the next	Is there an enrollee Coinsurance? Is there an enrollee Deductible? Is there an enrollee Copayment? Is authorization required? Is a referral required for Food and Notes:		
160.00  Every month  No  No  No  No  No	Is there an enrollee C Is there an enrollee D Is there an enrollee C Is authorization requir		
160.00  Every month  No  No  No  No	Is there an enrollee C Is there an enrollee D Is there an enrollee C Is authorization requir	**************************************	
160.00 Every month of-Pocket No No No	Is there an enrollee C Is there an enrollee D Is there an enrollee C		
160.00  Every month  of-Pocket No  No	Is there an enrollee C		
160.00 Every month of-Pocket No	Is there an enrollee C	The state of the s	
of-Pocket			6
160.00 Every month	Is there a service-spe Cost?		
5	Select Maximum Plan	v en sere	1
And the second control of the second control of the second control of the second control of the second district the second control of th	Indicate Maximum Plai		1
Is there a service-specific Maximum Plan Benefit Coverage Yes	Is there a service-spe amount?		
Select type of benefit for Food and Produce:  Mandatory	Select type of benefit	3	B
e Food and Produce as a supplemental Yes	Does the plan provide benefit under Part C?	vanjata manaziyan	į
Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes:  Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living	nefits for CI - Non-Primarily d Benefits for the	13i Additional Ber VBID/UF/SSB Health Relate Chronically III	19b - 1
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.	Notes:		
Response	Pry Question	ection Category	PBP Section
Benefit Description		Con triumpe and the	
Service Category Description	Ser		
Disease States:			
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	19b Additional Bene		

No	Is this benefit unlimited for number of trips for Any Location?		maga Magana
Fleet includes sedans, minivans, buses with hydraulic ramps.	Description:	The state of the s	
Van; Medical Transport  Contrato Número	Select Mode of Transportation for Non-Medical Need for Plan-approved Location:		
One-way 1924 - 0004	Select Type of Transportation for Non-Medical Needs for Plan-approved Location:		r
Every year	Select Plan-approved Location Trips periodicity:	The state of the s	6
O CHINS TO SECURIOR SECURIOR OF THE SECURIOR O	Indicate number of trips for Plan-approved Location:		
No ADMINISTRACION DE	Is this benefit unlimited for number of trips for Planapproved Location?	. 1	1
Mandatory	Select type of benefit for Plan-approved Location:	The state of the s	N. W.
Plan-approved Location	Select enhanced benefit:	Decree plants prints are the	
Yes	Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?		
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.	Notes:		
No	Is a referral required for Pest Control?		
No	Is authorization required?	And the second of the second o	
No	Is there an enrollee Copayment?		
No	Is there an enrollee Deductible?	100 mm 1000 1000 100 mm m	
No	Is there an enrollee Coinsurance?	Shell and white him state	the distance
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Mandatory	Select type of benefit for Pest Control:		
Response	Question	on Category	PBP Section
	Benefit Description		
	Service Category Description		na nao ao a
	Disease States:		Marie No.
kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		A-4012.1 V

しがら	No	Is there an enrollee Coinsurance?		
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?		
Contrato Número	Every month	Select Maximum Plan Benefit Coverage periodicity:		
	0.00	Indicate Maximum Plan Benefit Coverage amount:		; f
№24-0004	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
SEGUROS DE SALUD	Mandatory	Select type of benefit for Indoor Air Quality Equipment and Services:		
AD MOIDA ATSINIMATE A	Yes	Does the plan provide Indoor Air Quality Equipment and Services as a supplemental benefit under Part C?		
Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.	Transportatio trips are a co and 13i4 - Tr	Notes:	70 11	The
	No	Is a referral required for Transportation for Non-Medical Needs?		
407	No	Is authorization required?		mm a document
The Market Co.	No	Is there an enrollee Copayment?		
	No	Is there an enrollee Deductible?		
	No	Is there an enrollee Coinsurance?		
7	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Fleet includes sedans, minivans, buses with hydraulic ramps.	Fleet includes ramps.	Description:	The state of the s	
Transport	Van; Medical Transport	Select Mode of Transportation for Non-Medical Needs for Any Location:	7	A
	One-way	Select Type of Transportation for Non-Medical Needs for Any Location:	ī	
	Every year	Select Any Location Trips periodicity:		
	0	Indicate number of trips for Any Location:		
20102	Response	Question	Category	PBP Section
		Benefit Description		
		Service Category Description		200 TOBA AAA AAA
		Disease States:		
	kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1		

	19b Additional Benefits for VBLD/UF/SSBC1 - VBLD Package 1	Sign I
	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
The second secon	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
1	Is there an enrollee Deductible?	No
	Is there an enrollee Copayment?	No
<b>&gt;</b>	Is authorization required?	No
	Is a referral required for Social Needs Benefit?	No

SEGUROS DE SALUD

SEGUROS DE SALUD

Contrato Número

SALUD

CONTRATO Número

variety of natural products, including herbs, dietary supplements, and prebiotic or probiotic products are also commonly used (NCCIM, 2016a).	variety of natural products, inclu supplements, and prebiotic or procommonly used (NCCIM, 2016a).			
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	Complementary therapic Card. They are increasil medicine, which include manage symptoms asso Common complementary and body interventions manipulation, yoga, mas	Notes:		X
	No	Is a referral required for Complementary Therapies?		M Carrie
Contrato Numero	No	Is authorization required?		
	No	is there an enrollee Copayment?	AND ADDRESS OF THE PARTY OF THE	
	No.	Is there an enrollee Deductible?		
00-700	No	Is there an enrollee Coinsurance?		
SEGUROS DE SAL	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		A v - Culty
ADMINISTRACI	Every month	Select Maximum Plan Benefit Coverage periodicity:	The transformation of	
Miles	0,00	Indicate Maximum Plan Benefit Coverage amount:	1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 .	
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
	Mandatory	Select type of benefit for Complementary Therapies:		
	Yes	Does the plan provide Complementary Therapies as a supplemental benefit under Part C?		*
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.	Social Needs are covered through the SSI include access to community or plan spon address social needs, events that address improve emotional and/or cognitive function cognitive function. Club memberships, parmusical events, counseling. This includes concerts, museums, community entertain gardening, arts and crafts, in addition to support attendance to all aforementioned events/activities.	Notes:		
to make a security and the security and	Response	Question	Category	PBP Section
And And September to Another September to Management and Another September 1997		Benefit Description		o esperi
		Service Category Description		
		Disease States:		
	kage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Packag		

SWR

	No	Is authorization required?		
	No	Is there an enrollee Copayment?		ś
Contrato Número	No	Is there an enrollee Deductible?		
	No	Is there an enrollee Coinsurance?		
₩24-0004	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	3	5
SEGUROS DE SALUD	No	Is there a service-specific Maximum Plan Benefit Coverage amount?		~
ADMINICTO	Mandatory	Select type of benefit for General Supports for Living:	7	1
	Yes	Does the plan provide General Supports for Living as a supplemental benefit under Part C?		,
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.	Services support SSBCI Card and financial and oth education.	Notes:		
	No	Is a referral required for Services Supporting Self- Direction?		J
	No	Is authorization required?		
and the state of t	No	Is there an enrollee Copayment?		
	No	Is there an enrollee Deductible?	The state of the s	
	No	Is there an enrollee Coinsurance?		
no de manado.	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
The state of the s	Every month	Select Maximum Plan Benefit Coverage periodicity:	The second secon	
§ :	0.00	Indicate Maximum Plan Benefit Coverage amount:		
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?		
	Mandatory	Select type of benefit for Services Supporting Self- Direction:		
	Yes	Does the plan provide Services Supporting Self-Direction as a supplemental benefit under Part C?		
	Response	Question	PBP Section Category	PBP Se
755 47	The former of the second secon	Benefit Description	And and the second	
		Service Category Description		
		Disease States:		
	age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package		

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### **PBP Section** 196 - 13i Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Category Chronically III Is there a service-specific Maximum Enrollee Out-of-Pocket Cost? Is there a service-specific Maximum Plan Benefit Coverage amount? Select type of benefit for Other 2: Is there an enrollee Deductible? Select type of benefit for Other 1: Is a referral required for General Supports for Living? Question Enter name of Service: Is a referral required for Other 1 Services? Is authorization required? Is there an enrollee Copayment? Is there an enrollee Coinsurance? Enter name of Service: Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes: Notes: Notes: 19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Service Category Description **Benefit Description** Disease States: N pest control, home assistance services filed in General Supports for Living, pet grooming, and Hairstyling. disinfection and yard clean-up, which is combined with Member may choose up to two (2) services per quarter (8 visits annually) of home cleaning, including preventive 8 8 8 8 8 4. Hurricane preparedness items - first aid kit, flashlight, batteries, radio, sleeping bag/blanket, utensils, paper, cleaning, pet grooming, and Hairstyling. The following additional items are covered through the SSBCI Card:1. Mandatory Pet care 8 Home cleaning Other 1; Other 2; Other 3; Other 4 Mandatory Hardware/tools to support house maintenance/appliances Gasoline and auto repairs 2. Cleaning Products 3. Assistance. These are combined with pest control, home repairs, Electrical repairs, Locksmith, and basic Technology visits annually) for Home Assistance such as Plumbing Member may choose up to two (2) services per quarter (8 Response ADMINISTRACION DE SEGUROS DE SALUD Contrato Número

								5	2					The state of the s							PBP Section Category	A COLUMN TO THE			
as a reterior required for Other's Services?	Is authorization required?	is there an enrollee copayment?	Is there an enrollee Deductible?	an enrollee	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 3:	Enter name of Service:	Notes:	Is a referral required for Other 2 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Question	Benefit Description	Service Category Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package
	No	No Contrato Muneto			N <sub>0</sub>	Every month SEGUROS DE SALUA	0.00 ADMINISTRACION DE	Yes	Mandatory	Memory Fitness and Cognitive Function	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.	No	No	No	No	No	No	Every month	0.00	Yes	Response	The state of the s			ckage 1

### **PBP Section** Category Is a referral required for Other 4 Services? Is authorization required? Is there an enrollee Copayment? Is there an enrollee Deductible? Is there an enrollee Coinsurance? Is there a service-specific Maximum Enrollee Out-of-Pocket | No Cost? amount? Is there a service-specific Maximum Plan Benefit Coverage Select type of benefit for Other 4: Enter name of Service: Notes: Question 19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Service Category Description **Benefit Description** Disease States: 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 8 S 8 8 8 cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the SSBCI Card. for Living, home cleaning, and pet grooming. $\frac{8}{6}$ Mandatory Hairstyling function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, Items/services that support memory fitness and cognitive Response

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ADMINISTRACION DE SEGUROS DE SALUD

Nº24-0004

### **Bid Reports 2024**

## **PBP Part D Benefits Report**

H5577 - 054 1 MCS ADVANTAGE, INC.

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Segment ID: Plan Geographic Name:

Segment Geographic Name:

Status:

Enrollee Type: Plan Type:

Visitor/Travel Benefit Available:

Continuation Area Available: Part D Plan Premium: Number of Tiers:

Formulary:

Yes, Defined Standard

Dual-Eligible

Dual-Eligible SNP: Special Needs Plan Type: Special Needs Plan: Part D Benefit:

New York

MCS Classicare New York

MCS Classicare Platino Maximo (HMO D-SNP)

Puerto Rico

Region 1

Version 2 - Renewal - Successfully exported to desk review

(06/06/23)

Part A and Part B

Yes, 00024446

Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE SEGUROS DE SALUD,

№24-0004

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

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

\$105.00	Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three monthsupply:
	Cost-Sharing two month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Cost-Sharing one month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Sharing three month supply:
\$105.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing two month supply:
\$70.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing one month supply:
\$35.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Indicate which tiers have insulin drugs (Select all that apply):
Sponsor attests that it will comply with 42 CFR 423.154.	Sponsor attestation
No	Notes Available
Term Care	
Standard Retail; Out-of-Network; Standard Mail-Order; Long-	Pharmacy Network Components
	Utilization Management Program
No	You pay for Over-the-Counter medications (OTCs) under the
	Enrollee Out-of-Pocket Cost Threshold
5030.00	Initial Coverage Limit
25%	Pre-ICL Cost Shares
545.00	Deductible
Plan Data	Benefit
nefit Data	Part D Benefit Data

ADMINISTRACION DE SEGUROS DE SALUD,

心24-0004

EMR Contrato Número

	Cost Shares Above the Threshold
formulary model documents.	
vaccines will be designated as such on the beneficiary-facing	
regardless of tier placement or benefit phase. The applicable	
sales tax, dispensing fee, or vaccine administration fee,	
the prescription drug event (PDE) record, or any associated	
sharing on the ingredient cost of the vaccine submitted on	
Immunization Practices (ACIP). There is no enrollee cost	
adult vaccine recommended by the Advisory Committee on	
l attest that there is no deductible and no cost sharing for an	Vaccine Attestation:
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment Amount for Long Term Care
	Pharmacy other day supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network

Gene	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-	Yes
month supply for the first fill?	
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	ne ICL and Cost Shares - Above the Threshold

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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

VBID - Part C	VBID - Part D Benefit Data
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and	No
Incentives under the VBID Model?	
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 SEGUROS DE SALUD;

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Contrato Número

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## **PBP Part D Benefits Report**

H5577 - 054 2 MICS ADVANTAGE, INC.

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region:

Org. Marketing Name: Plan Name:

Plan Geographic Name:

Segment ID: Segment Geographic Name:

Status:

Enrollee Type: Plan Type:

US - No

Yes, 00024446

Yes, Defined Standard

Special Needs Plan:

Part D Benefit: Formulary:

Dual-Eligible SNP: Special Needs Plan Type:

New York

New York

MCS Classicare

MCS Classicare Platino Maximo (HMO D-SNP)

Puerto Rico

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

Part A and Part B

Continuation Area Available:

Part D Plan Premium: Number of Tiers:

Visitor/Travel Benefit Available:

Dual-Eligible

Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE SEGUROS DE SALUD №24-0004

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

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

\$105.00	Indicate Insulin Copayment amount for Standard Mail Order Cost-Sharing three month supply:
	Cost-Sharing two month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Cost-Sharing one month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Sharing three month supply:
\$105.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing two month supply:
\$70.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing one month supply:
\$35.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Indicate which tiers have insulin drugs (Select all that apply):
Sponsor attests that it will comply with 42 CFR 423.154.	Sponsor attestation
No	Notes Available
Term Care	
Standard Retail; Out-of-Network; Standard Mail-Order; Long-	Pharmacy Network Components
	Utilization Management Program
No	You pay for Over-the-Counter medications (OTCs) under the
	Enrollee Out-of-Pocket Cost Threshold
5030.00	Initial Coverage Limit
25%	Pre-ICL Cost Shares
545.00	Deductible
Plan Data	Benefit
Part D Benefit Data	Part D Be

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ADMINISTRACION DE SEGUROS DE SALUD

Contrato Número

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	Cost Shares Above the Threshold
TOTTITUTALY ITTOUEL DOCUMENTS.	
vaccines will be designated as such on the beneficiary-facing	
regardless of tier placement or benefit phase. The applicable	
sales tax, dispensing fee, or vaccine administration fee,	
the prescription drug event (PDE) record, or any associated	
sharing on the ingredient cost of the vaccine submitted on	
Immunization Practices (ACIP). There is no enrollee cost	
adult vaccine recommended by the Advisory Committee on	
lattest that there is no deductible and no cost sharing for an	Vaccine Attestation:
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment Amount for Long Term Care
	Pharmacy other day supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network

General Data	a) 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-	Yes
month supply for the first fill?	
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	e ICL and Cost Shares - Above the Threshold

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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

VBID - Part I	VBID - Part D Benefit Data
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and	No
Incentives under the VBID Model?	
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 SECUROS DE SALUJ

№ 2 4 - 0 0 0 4

Contrato Número

SMR

## **PBP Part D Benefits Report**

H5577 - 054 3 MICS ADVANTAGE, INC.

VBID: Yes - Part C

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

Plan Geographic Name:

Segment ID:

Segment Geographic Name:

Status:

Number of Tiers: Enrollee Type: Plan Type:

Dual-Eligible

New York

New York

MCS Classicare

MCS Classicare Platino Maximo (HMO D-SNP)

Puerto Rico

Region 3

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

Part A and Part B

US - No

Yes, 00024446

Yes, Defined Standard

Special Needs Plan Type: Special Needs Plan:

Part D Benefit:

Formulary:

Visitor/Travel Benefit Available: Continuation Area Available: Part D Plan Premium:

Dual-Eligible SNP:

Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

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

, route	Cost-Sharing three month supply
\$105 DO	Indicate Insulin Consument amount in Standard Mail Order
	Cost-Sharing two month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Cost-Sharing one month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Sharing three month supply:
\$105.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing two month supply:
\$70.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing one month supply:
\$35.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Indicate which tiers have insulin drugs (Select all that apply):
Sponsor attests that it will comply with 42 CFR 423.154.	Sponsor attestation
No	Notes Available
Term Care	
Standard Retail; Out-of-Network; Standard Mail-Order; Long-	Pharmacy Network Components
	Utilization Management Program
No	You pay for Over-the-Counter medications (OTCs) under the
	Enrollee Out-of-Pocket Cost Threshold
5030.00	Initial Coverage Limit
25%	Pre-ICL Cost Shares
545.00	Deductible
Plan Data	Benefit
nefit Data	Part D Benefit Data

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	Cost Stidles Above the Hilleshold
	Cost Charac About the Throshold
formulary model documents.	
vaccines will be designated as such on the beneficiary-facing	
regardless of tier placement or benefit phase. The applicable	
sales tax, dispensing fee, or vaccine administration fee,	
the prescription drug event (PDE) record, or any associated	
sharing on the ingredient cost of the vaccine submitted on	
Immunization Practices (ACIP). There is no enrollee cost	
adult vaccine recommended by the Advisory Committee on	
I attest that there is no deductible and no cost sharing for an	Vaccine Attestation:
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment Amount for Long Term Care
	Pharmacy other day supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network
	Pharmacy one month supply:
\$35.00	Indicate Insulin Copayment amount for Out-of-Network

Gener	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-	Yes
month supply for the first fill?	
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	e ICL and Cost Shares - Above the Threshold
3.8.7	

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

VBID - Part D Benefit Data	Benefit Data
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and	No
Incentives under the VBID Model?	
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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ADMINISTRACION DE SEGUROS DE SALUD,

#### Plan Service Area Report

MCS ADVANTAGE, INC. HS577 - 054 1

VBID: Yes - Part C

MA Uniformity Flexibility: No Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region:
Org. Marketing Name:
Plan Name:

Plan Geographic Name: Segment ID: Segment Geographic Name: Status:

Plan Type:

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?

Enrollee Type:
Part C Plan Premium:
Part D Plan Premium:
Continuation Area Available:
Visitor/Travel Benefit Available:
Formulary: Part D Benefit:

New York
New York
MCS Classicare
MCS Classicare Platino Maximo (HMO D-SNP) Puerto Rico

Version 2 - Renewal - Successfully exported to desk
HIMO
Part A and Part B
\$0.00

N/A
No
US-No
Yes, 00024445
Yes, Defined Standard
Yes
Dual-Eligible
Medicare non-zero dollar cost sharing plan
re
Yes

Standard Bid For Section B: Standard Bid For Section C: Standard Bid For Section D: 2 2 Z

State Puerto Rico

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uerto Rico uerto Rico

1111	No.	100									
		Camuv		Arecibo		Anasco		Aguadilla		Aguada	
		40140		40070		40060		40030			County Code
	·	No		No		No		No		No	Employer-Only County?
		No		No		No		No		No	Pending County?
	Zipcode(s): 00627; 00670	Nb	Zipcode(s): 00612; 00613; 00614; 00616; 00652; 00688	No	Zipcode(s): 00610; 00670	No	Zipcode(s): 00603; 00604; 00605; 00690	No	Zipcode(s): 00602	No	Partial County?

EMR 1024-0004 ADMINISTRACION DE SECUROS DE SALUD

	Puerto Rico	Puerto Rico	Puerto Rico	Puerto Rico	Puerta Rico	Puerta Rico	Puerto Rico	Puerto Rico
	Utuado	San Sebastian	Rincon	Quebradilias	Moca	Mayaguez	Isabela	Hatillo
	40710	40660	40580	40570	40490	40480	40350	40320
	No	8	No	No	No	No	No	No
	No	8	No	No	No	No	No	No
Zipcode(s): 00611; 00641	No	No Zipcode(s): 00685	No Zipcode(s): 00677	No Zipcode(s): 00678	No Ziprode(s): 00676	No Ziprode(s): 00680; 00681; 00682	No Ziprode(s): 00662	No Zipcode(s): 00659

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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

EMR Contrato Número

### Plan Service Area Report

MCS ADVANTAGE, INC. H5577 - 054 2

VBID: Yes - Part C MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region: Org. Marketing Name: Plan Name: Plan Geographic Name:

New York
New York
MCS Classicare
MCS Classicare Platino Maximo (HMO D-SAP)
Puerto Rico

Segment Geographic Name: Segment ID:

Version 2 - Renewal - Successfully exported to desk review (06/06/23)
HMO
Part A and Part B
\$0.00
N/A

Plan Type:
Errollee Type:
Part C Plan Premium:
Part D Plan Premium:
Continuation Area Available:
Visitor/Travel Benefit Available:

No US - No Yes, 00024446 Yes, Defined Standard Yes

Part D Benefit: Formulary:

Medicare non-zero dollar cost sharing plan Yes Dual-Eligible

Special Needs Plan:
Special Needs Plan Type:
Special Needs Plan Type:
Dual-Eligible SNP:
Under this U-SNP, has the state agreed to cover all Medicare
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

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Adjuntas	40010	No		No
					Zipcode(s): 00601
Puerto Rico	Barceloneta	40090	No	No	No
					Zipcode(s): 00617
Puerto Rica	Cabo Rojo	40120	No	No	No
					Zipcode(s): 00622; 00623
Puerto Rico	Ciales	40190	No	No	No
					Zipcode(s): 00638
I II Common					

ADMINISTRACION DE SEGUROS DE SALUD

神24-0004

	Puerto Rico	דעפונט חוניט	District Dis	Puerto Rico		Puerto Rico		Puerto Rico	Puerto Nico		Puerto Rico		Puerto Rico	Puerto Rico		Puerto Rico		Puerto Rico	Puerto Nico		Puerto Rico		Puerto Rico	Fuerto Nico	7	Puerto Rico		Puerto Rico
	Yauco	스타스 아이스	idean Bain	Vega Alta		San German		Sabana Grande	Orocovis		Morovis		Maricao	Manati		Las Marias		lares	raj as		Јауиуа		Harmigueros	Guanica		Florida		Corozal
	40770	40.30	A0730	40720		40630		40610	40530		40500		40460	40450		40410		40400	40390		40360		40330	40770	2010	40265		40230
	No	N	20	20		No		No	No		No		No	Z <sub>0</sub>		No		No	20		No		No	NG		No		No
	No	W	5	No		No		No	No		No		No	z o		No		No	W		No		No	NG.		No		No
Zipcode(s): 00698	No	Zipcode(s): 00693; 00694	No.	No Zipoode(s): 00692: 00694	Zipcode(s): 00636; 00683	No	Zipcode(s): 00637	No	No Zipcode(s): 00720	zibcode(s): nneo/	No	Zipcode(s): 00606	No	No Zipcode(s): 00674	Zipcode(s): 00670	No	Zipcode(s): 00631; 00669	No	Zipcode(s): 00667	Zipcode(s): 00664	No	Zipcode(s): 00660	No	Zipcode(s): 00647; 00653	Months and the second	No Zipcode(s): 00650	Zipcode(s): 00783	No

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SEGUROS DE SALUD.

№ 2 4 - 0 0 0 4

#### Plan Service Area Report

MCS ADVANTAGE, INC.
H5577 - 054 3
VBID: Yes - Part C
MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Lead Marketing Region:
Org. Marketing Name:
Plan Name:

Segment Geographic Name: New York
New York
New York
MCS Classicare
MCS Classicare Platino Maximo (HMO D-SNP) Puerto Rico

Plan Geographic Name: Segment ID:

Region 3
Version 2 - Renewał - Successfully exported to desk

review (06/06/23) HMO

Part A and Part B \$0.00

Enrollee Type:
Part C Plan Premium:
Part D Plan Premium:
Continuation Area Available:

Plan Type:

No US - No Yes, 00024446 Yes, Defined Standard Yes Dual-Eligible

Special Needs Plan:
Special Needs Plan Type:
Dual-Eligible SNP:

Part D Benefit:

Visitor/Travel Benefit Available:

Medicare non-zero dollar cost sharing plan

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

Standard Bid For Section B: Standard Bid For Section C: Standard Bid For Section O:

N 0 0

State Puerto Rico

Puerto Rico

Puerto Rico uerta Rica

	Barranquitas		Arroyo		Aibonito		Aguas Buenas	County
h	40100		40080		40050		40040	County Code
	No		No		No		No	Employer-Only County?
	No		No		No		No	Pending County?
Zipcode(s): 00794	No	Zipcode(s): 00714	No	Zipcode(s): 00705; 00786	No	Zipcode(s): 00703	No	Partial County?

ADMINISTRACION DE SEGUROS DE SALUJ

EMR #24-0004

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SECTION DE	SECT			The state of the s	
Zipcode(s): 00741; 00745; 00791; 00792					
No	No	200	40340	numacao 4	FUEL TO NIGO
Zipcode(s): 00778					
No	No	No	40310	Gurabo 4	Puerto Rico
Zipcode(s): 00934; 00965; 00966; 00968; 00969; 00970; 00971					
No	No	No	40300	Guaynabo 4	Puerto Rico
Zipcode(s): 00656; 00785					
No	No	No	40290	Guayanilla 4	Puerto Rico
No N	No	No	40280	Guayama	Puerto Rico
Zipcode(s): 00738; 00740					
No	No	No	40260	Fajardo 4	Puerto Rica
Zipcode(s): 00646					
No	No	No	40250	Dorado	Puerto Rico
No Zincode(s): no275	Zo	Zo	40240	Culebra	PURTO KICO
Zipcode(s): 00782					
No	No	No	40220	Comerio	Puerto Rico
Ziprade(s): 00769					
No	No	No o	40210	Coamo	Puerto Rico
Zipcode(s): 00739					
No	No	No	40200	Cidra	Puerto Rico
No Zipcode(s): 00735; 00742	No	NO	латон	Core	
Zipcode(s): 00736; 00737					Pierro Rico
No	No	No	40170	Cayey	Puerto Rico
Zipcode(s): 00962; 00963					
Nο	No	No	40160	Catano	Puerto Rico
Ziprode(s): 00979; 00981; 00982; 00983; 00984; 00985; 00986; 00987; 00988					
No	No	No	40150	Carolina	Puerto Rico
Zipcode(s): 00729; 00745	100	100			
riprode(s), pozza, pozza, pozza	2	No	40145	Canovanis	Puerto Rico
No 7 incode(s): 00775: 00777	No	No	40130	Caguas	Puerto Rico
Zipcode(s): 00934; 00956; 00957; 00958; 00959; 00960; 00961					
No	No	No	40110	Bayamon	Puerto Rico

EMR Contrato Número

M24-0004

zipcbae(s): 00953; 00954				211	
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Zipcodels): UU/5/		NO.	40680	Tog Alla	Puerto Rico
11.01.0011					
No	20	20	40670	Santa Isabei 40	Puerto Rico
Zincode/st: 00754					
No	No	No	40650	San Lorenzo 40	Puerto Rico
00909; 00910; 00911; 00912; 00913; 00914; 00915; 00916; 00907; 00918; 00919; 00920; 00921; 00923; 00923; 00923; 00923; 00923; 00923; 00923; 00933; 00933; 00939; 00					
Zipcode(s): 00901; 00902; 00905; 00906; 00907; 00908;	No	NO	*UV4U	Sur Man	OF TAX INVO
Zipcode(s): 00704; 00751					
No	No	No	40620	Salinas 40	Puerto Rico
Zipcade(s): 00721; 00745					
N <sub>D</sub>	No	No	40590	Rio Grande 40	Puerto Rico
No Zipcode(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732: 00733: 00734: 00780	No.	NO	40000	FOILE	
cipcoacts), page					Pierto Biro
No Zinrode(s): 00624	No	No	40550	Penuelas 4	Puerto Rico
Zipcode(s): 00723					
No	No.	No	40540	Patillas 4	Puerto Rico
No Pinrodelet 00718	Ño	No	40520	Naranjito 40	Puerto Rico
Zipcode(s): 90718; 90744					
No	No	No	40510	Naguabo 4	Puerto Rico
No Ziprodels): 00707	No	No	40470	Maunabo 4	Puerto Rico
Zipcade(s): 00773					
No	No	No	40440	Luquillo 4	Puerto Rica
No Zipcode(s): 00772	20	NO O	40430	L0122	Puerto Rico
Zipcode(s): 00771					
No	No	No	40420	Las Piedras 4	Puerto Rico
Zipcode(s): 00777					
No	No	No	40380	Juncos 41	Puerto Rico
Zipcode(s): 00795					
No	No	No	40370	Juana Diaz 4	Puerto Rico

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ADMINISTRACION DE SEGUROS DE SALUD

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	Puerto Rico		Puerta Rica		Puerto Rica		Puerto Rico		Puerto Rico
	Pabucoa		Villalba		Viegues		Trujillo Alto		Toa Baja
	40760		40750		40740		40700		40690
	No		No		20		No		No
	J		t c						3
	No		No		No		No		No
Zipcode(s): 00767	No	Zipcode(s): 00766	No	Zipcode(s): 00765	No	Zipcode(s): 00976; 00977; 00978	No	Zipcode(s): 00949; 00950; 00951; 00952	No

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ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

# **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 III: No

Part D Senior Savings Model: No

Region:

Lead Marketing Region:

Plan Name: Org. Marketing Name:

Plan Geographic Name:

Segment ID:

Segment Geographic Name:

Status:

Plan Type:

Puerto Rico MCS Classicare Platino Maximo (HMO D-SNP) MCS Classicare New York New York

Version 2 - Renewal - Successfully exported to desk review Region 1

Part A and Part B

(06/06/23)

\$0.00

N/A 8

US - No

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Special Needs Plan Type: Special Needs Plan: Part D Benefit:

Formulary:

Visitor/Travel Benefit Available:

Continuation Area Available:

Part D Plan Premium: Part C Plan Premium: Enrollee Type:

Dual-Eligible SNP:

Medicare non-zero dollar cost sharing plan

CULIAS ECISORUDES,

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 C:	Standard Bid For Section B:	premiums and cost sharing for enrollees in your D-SNP?
No	No	Yes

Standard Bid For Section D:

No

Plan Level Cost 9	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	Yes
Cost?	
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Lower	Lower
Cost at the Lower, Intermediate or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00
Amount:	
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits
Enrollee Out-of-Pocket cost:	
Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all In-Network Medicare-covered plan services?	



ADMINISTRACION DE SEGURCS DE SALUD

M24-0004

EMIC Contrato Número

Services; 3-4: SET for PAD Services; 4a: Emergency Services; Psychiatric; 3-1: Cardiac Rehabilitation Services; 3-2: Intensive 1a: Inpatient Hospital-Acute; 1b: Inpatient Hospital Cardiac Rehabilitation Services; 3-3: Pulmonary Rehabilitation

Nursing Facility (SNF); 5: Partial Hospitalization; 6: Home Drugs; 16b: Comprehensive Dental; 17a: Eye Exams; 17b: Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B Education Services; 14e; 15-2: Medicare Part B covered Zero Dollar Preventive Services; 14d: Kidney Disease Durable Medical Equipment (DME); 11b; 11c; 14a: Medicare-Additional Telehealth Benefits; 7k: Opioid Treatment Program Services; 7d: Physician Specialist Services; 7f; Podiatry 4b: Urgently Needed Services; 7a: Primary Care Physician Eyewear; 18a: Hearing Exams; 12: Dialysis Services; 2: Skilled Services; 9d: Outpatient Blood Services; 9a; 9c; 10a; 11a: Services; 7e; 7h; 8a; 8b; 9b: Ambulatory Surgical Center (ASC) Therapy and Speech-Language Pathology Services; 7j: Services; 7g: Other Health Care Professional; 7i: Physical Services; 7b: Chiropractic Services; 7c: Occupational Therapy

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

The you offer Reductions in Cost Sharing?	No
Combined Ber	Combined Benefits - General
Question	Response
Do you offer Combined Supplemental Benefits?	Yes
Select the number of Combined Supplemental Benefit	2
packages you are offering?	
Combined Benefits Group 1 Name:	Combined Eyewear and Hearing

ADMINIGTE ACTION DE SEGUROS DE SALUD

M24-0004

your Combined Supplemental Benefit package:	1701: Contact Lenses; 1702: 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	No
supplemental benefits from the package which they must	
select in advance?	
Do you offer Combined Supplemental Benefits with a shared	Yes
maximum plan benefit amount?	
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	10b1: Transportation Services - Plan Approved Health-related
your Combined Supplemental Benefit package:	Location; 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of	Other
delivery?	
Other Description:	Transportation provided by contracted vendors.
Is the enrollee limited to one or more of the combined	No
supplemental benefits from the package which they must	
Do you offer Combined Supplemental Benefits with a shared	No
maximum plan benefit amount?	
Do you offer Combined Supplemental Benefits with a shared	Yes
visit limit?	
Indicate number of shared visits:	12
Select visit limit periodicity:	Every year

EMR #24-0004 ADMINISTRACION DE SEGUROS DE SALUJ

# **Plan Level Cost Shares and Limits Report**

H5577 - 054 - 2 MCS ADVANTAGE, INC.

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:

New York

New York

MCS Classicare

MCS Classicare Platino Maximo (HMO D-SNP)

Puerto Rico

Region 2

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

Part A and Part B

\$0.00

N/A

OS - No Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

Dual-Eligible SNP: Special Needs Plan Type: Part D Benefit:

Formulary:

Special Needs Plan:

Visitor/Travel Benefit Available:

Continuation Area Available: Part D Plan Premium:

ADMINISTRACION DE

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SEGUROS DE SALUA

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: No Yes

Standard Bid For Section D:

Plan Level Cost :	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	Yes
Cost?	
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Lower	Lower
Cost at the Lower, Intermediate or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00
Amount:	
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits
Enrollee Out-of-Pocket cost:	
Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all in-Network Medicare-covered plan services?	

ADMINISTRACION DE SEGUROS DE SALUD M24-0004

Select all of the In-Network Medicare-covered Service Categories that are INCLUDED in the In-Network Maximum Enrollee Out-of-Pocket Cost amount:

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

Reductions in Cost Sharing - General	General
Question Response	
Do you offer Reductions in Cost Sharing?	

Combined B	Combined Benefits - General
Question	Response
Do you offer Combined Supplemental Benefits?	Yes
Select the number of Combined Supplemental Benefit	2
packages you are offering?	
Combined Benefits Group 1 Name:	Combined Eyewear and Hearing

SEGURGS DE SALUD

EMP 1924-0004

Every year	Select visit limit periodicity:
12	Indicate number of shared visits:
Vpc	ental Renefits with a chared
C	maximum plan henefit amount?
	soloct in advance?
No	Is the enrollee limited to one or more of the combined
Transportation provided by contracted vendors.	Other Description:
	delivery?
Other	What is your combined supplemental benefits mode of
Location; 19b: Additional Benefits for VBID/UF/SSBCI	your Combined Supplemental Benefit package:
10b1: Transportation Services - Plan Approved Health-related	Select which non-Medicare covered benefits are included in
Combined Transportation	Combined Benefits Group 2 Name:
No	Do you offer Combined Supplemental Benefits with a shared visit/trip limit?
Every year	Select Maximum Plan Benefit Coverage Amount Periodicity:
600.00	Max Plan Benefit Amount:
	maximum plan benefit amount?
Yes	Do you offer Combined Supplemental Benefits with a shared
	select in advance?
	supplemental benefits from the package which they must
No	Is the enrollee limited to one or more of the combined
Combined Eyewear and Hearing Allowance	Other Description:
Other	What is your combined supplemental benefits mode of delivery?
1/b3: Eyeglass ienses; 1/b4: Eyeglass frames; 18b1: Hearing Aids (all types)	your combined Supplemental Benefit package:
17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames);	Select which non-Medicare covered benefits are included in

ADMINISTRACION DE SEGUROS DE SALUD

EMR 124-0004

# **Plan Level Cost Shares and Limits Report**

H5577 - 054 - 3 MICS ADVANTAGE, INC.

MA Uniformity Flexibility: No VBID: Yes - Part C

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:

Part C Plan Premium: Enrollee Type:

Part D Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Part D Benefit: Formulary:

Special Needs Plan:

Special Needs Plan Type:

Dual-Eligible SNP:

New York

New York

MCS Classicare

MCS Classicare Platino Maximo (HMO D-SNP)

Region 3

Puerto Rico

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

Part A and Part B

\$0.00

N/A

US - No

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

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:

Plan Level Cost Shares and Limits	hares and Limits
Question	Response
Is there an In-Network Plan Deductible?	No
Is there an In-Network Maximum Enrollee Out-of-Pocket	Yes
Cost?	
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Lower	Lower
Cost at the Lower, Intermediate or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00
Amount:	
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits
Enrollee Out-of-Packet cost:	
Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all In-Network Medicare-covered plan services?	

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ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

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:

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

Additional Telehealth Benefits; 7k: Opioid Treatment Program

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

Health Services

Combined Benefits Group 1 Name: Do you offer Combined Supplemental Benefits? packages you are offering? Select the number of Combined Supplemental Benefit Question Combined Benefits - General Yes Combined Eyewear and Hearing Response

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ADMINISTRACION DE SEGUROS DE SALUD

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Every year	Select visit limit periodicity:
12	Indicate number of shared visits:
Yes	Do you offer Combined Supplemental Benefits with a shared visit limit?
No	Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?
	select in advance?
,	supplemental benefits from the package which they must
Transportation provided by contracted vendors.	Other Description:  Is the enrollee limited to one or more of the combined
	delivery?
Other	What is your combined supplemental benefits mode of
Location; 19b: Additional Benefits for VBID/UF/SSBCI	your Combined Supplemental Benefit package:
10b1: Transportation Services - Plan Approved Health-related	Select which non-Medicare covered benefits are included in
Combined Transportation	Combined Benefits Group 2 Name:
	visit/trip limit?
No	Do you offer Combined Supplemental Benefits with a shared
Every year	Select Maximum Plan Benefit Coverage Amount Periodicity:
600.00	Max Plan Benefit Amount:
	maximum plan benefit amount?
Yes	Do you offer Combined Supplemental Benefits with a shared
	select in advance?
	supplemental benefits from the package which they must
No	Is the enrollee limited to one or more of the combined
Combined Eyewear and Hearing Allowance	Other Description:
	delivery?
Other	What is your combined supplemental benefits mode of
Aids (all types)	
17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing	your Combined Supplemental Benefit package:
17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames);	Select which non-Medicare covered benefits are included in

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ADMINISTRACION DE SEGUROS DE SALUD

	\$100.00	nstructions)	\$164,90 2. Part B Rebate Allocation, rounded to one decimal (see in	\$164.90 2.	bayaowii ana., poi	CMS
	\$100.00	value=\$164.90)	1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90)		hivdown amt ner	1 Maximum Pt B premium buydown amt iner
			B. Rebate Allocation for Part B Premium	<b>53</b>		A. Part B Information
						II. Other Information
14. SNP Type:	~	12. SNP:	~	8. MA-PD:	2024	4. Contract Year:
	Z	<ol><li>Act. Swap/Equiv Apply:</li></ol>	HMO	<ol><li>Plan Type:</li></ol>	001	<ol><li>Segment ID:</li></ol>
	N/A	10. MA Region:	SNP)	<ol><li>Plan Name:</li></ol>	054	2. Plan ID:
13. Region Name:	A/B	9. Enrollee Type:	ne: MCS ADVANTAGE, INC. MCS Classicare Platino Maximo (HMO D-	5. Organization Name:	H5577	1. Contract Number:
						I. General Information
					A BID	WORKSHEET 6 - MA BID SUMMARY

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ADMINISTRACION DE SEBUROS DE SALUD

EMR 1024-0004

# WORKSHEET 6 - MA BID SUMMARY

\$100.00	instructions)	\$164.90   2. Part B Rebate Allocation, rounded to one decimal (see	\$164.90   2. Part		CMS
	lm value=\$164.90)	1. PMPM Rebate Allocation for Part B premium (maximum value=\$164.90	1. PM	buydown amt., per	1. Maximum Pt B premium buydown amt., per
		B. Rebate Allocation for Part B Premium	B. Ret		A. Part B Information
					II. Other Information
Y 14. SNP Type:	12. SNP:		8. MA-PD:	2024	4. Contract Year:
Apply: N	11. Act. Swap/Equiv	HMO	7. Plan Type:	002	3. Segment ID:
N/A	10. MA Region:	SNP)	6. Plan Name:	054	2. Plan ID:
13. Region A/B Name:		MCS ADVANTAGE, INC. MCS Classicare Platino Maximo (HMO D-	5. Organization Name:	H5577	1. Contract Number:

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EMR 1924-0004

# WORKSHEET 6 - MA BID SUMMARY

MICS Classicale	IVICO CIASSICATE FIAUNO MAXINO (FIVIO D-			
2. Plan ID: 054 6. Plan Name: SNP)	10.	10. MA Region:	N/A	
One 7 Blog Time:	4	A A of Swap/Paulin Apply:	Z	
		. Code Caraba malana . John J.	:	
r: 2024	12.	12 SNP:	<	14 CND Tuno
II. Other Information		. 0.0	~	14. ONL TAPE.
A. Part B Information B. Rebate Allocation for Part B Premium			-<	14. ONF 1) pe
	art B Premium			it. ONE Type
	art B Premium for Part B premium (maximum value	n value=\$164.90)	\$100.00	
ium buydown amt., per	art B Premium for Part B premium (maximum value	e=\$164.90)	\$100.0	

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ADMINISTRACION DE SEGUROS DE SALUD

№24-0004



#### Appendix C-I

#### Plan Benefit Package (PBP)

H5577 - 055

ADMINISTRACION DE SEGUROS DE SALUD

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## PBP Benefits Report

VBID: Yes - Part C H5577 - 055 MCS ADVANTAGE, INC.

MA Uniformity Flexibility: No

Special Supplemental Benefits for the Chronically III: No

Part D Senior Savings Model: No

Plan Geographic Name: Org. Marketing Name: Lead Marketing Region: Plan Name: Region:

Segment Geographic Name: Segment ID:

Plan Type:

nrollee Type:

Part D Plan Premium: ar C Plan Premium:

Continuation Area Available:

Visitor/Travel Benefit Available:

Formulary:

Special Needs Plan:

Special Needs Plan Type:

Dual-Eligible SNP:

Standard Bid For Section B:

8 8 8

Plan Level Data

Question

Part D Benefit:

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

Standard Bid For Section C:

Standard Bid For Section D:

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)

Part A and Part B

\$0,00

N/A

US - No

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

Medicare non-zero dollar cost sharing plan

Yes

ADMINISTRACION DE SEGUROS DE SALUD

№24-0004

Contrato Número

Response

Tiered Cost sharing for Part B Services	ces
to provide the second s	The state of the s
Question	Response
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services No 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
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

	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
Contrato Número	No	Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?
and the same of th	Response	Question
10004		Benefit Description
		Service Category Description
SEGUROS DE SALUD		1b Inpatient Hospital-Psychiatric
		AND THE RESIDENCE OF THE PROPERTY OF THE PROPE

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

	Question			
2 Chilled Nursing Escility (CNE)	Response	Benefit Description	Service Category Description	1b Inpatient Hospital-Psychiatric

2 Skilled Nursing Facility (SNF) Service Category Description	
Benefit Description	The state of the s
Question	Response
an provide Skilled Nursing Facility Services as a supplemental benefit un	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 ADMINISTRACION DE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No SEGURUS DE SALUD
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	№ 24-0004
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No Contrato Número
What is your SNF benefit period?	Original Medicare

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Control of the con	
Yes	Is authorization required?
No	Do you charge cost sharing on the day of discharge?
Response	Question
TO AN A	Benefit Description
	Service Category Description
	2 Skilled Nursing Facility (SNF)

2 Skilled Nursing Facility (SNF)	1
Service Category Description	
Benefit Description	
Question	Response
3 Cardiac and Pulmonary Rehabilitation Services	ervices
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 ADMINISTRACION DE
Indicate Minimum Copayment amount per service for Medicare-covered Intensive Cardiac Rehabilitation Services:	\$0.00 STGUKUS DE SALUD
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 Contrato Número
Indicate Maximum Copayment amount per service for Medicare-covered Pulmonary Rehabilitation Services:	\$0.00

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3 Cardiac and Pulmonary Rehabilitation Services	Services
Service Category Description	
Benefit Description	
Indicate Minimum Copayment amount per service for Medicare-covered Supervised Exercise Therapy (SET) for Symptomatic Peripheral Artery Disease (PAD) Services:	0
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	Services
Service Category Description	
Benefit Description	
Question	
4a Emergency Services	
Service Category Description	
Question	1
imum	No
Is there an enrollee Coinsurance?	No
	No

Question				Question				
Response	Benefit Description	Service Category Description	4b Urgently Needed Services	Response	Benefit Description	Service Category Description	4a Emergency Services	epicado
	and department of the same of	Contrato Número	" " " " " " " "	1000 / Cill	SEGUROS DE SALUD	ADMINISTRACION DE		To the same of the

4b Urgently Needed Services	lices
Service Category Description	ption
Benefit Description	
- 1	Response
ce-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
A MARIA CALIFORNIA MACIA	of the desire that and the control between the control the control that th

4c Worldwide Emergency/Urgent Coverage	verage
Service Category Description	
Benefit Description	
Question	Response
oes 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 SECTIBLE DE CON DE
Is there an enrollee Copayment?	No The state of th
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	\$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	•
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	\$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	\$0.00 Contrato Número
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	3
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
	C. Principal C. Pr

The same of the sa	The second secon	AAAA TERMINI MINOR
6 Home	6 Home Health Services	
Service Ca	Service Category Description	
Benef	Benefit Description	
Quastion		
If there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	THE THE PARTY OF T
Is there an enrollee Copayment?		,
Is authorization required?	Yes	
Is a referral required for Home Health Services?	Yes	

7a Primary Care Physician Services	es	
Service Category Description		
Benefit Description	4. Tables &	All and the state of the state
Question	Response	· · ALMINIGUEACE
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	SEGUROS DE SALUA
Is there an enrollee Coinsurance?	No	
Is there an enrollee Deductible?	No	№ 2 4 - 0 0 0 4
Is there an enrollee Copayment?	No	

Contrato Número

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7b Chiropractic Services	es
Service Category Description	ption
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

	Out-of-Pocket Cost?		Benefit Description	Service Category Description	7c Occupational Therapy Services
No	No	Response	THE PROPERTY OF	3	Ces

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Contrato Número

Is a referral required for Occupational Therapy Services?

Is there an enrollee Coinsurance?
Is there an enrollee Deductible?
Is there an enrollee Copayment?
Is authorization required?

Yes No

Is there a service-specific Maximum Enrollee

7d Physician Specialist Services excluding Psychiatric Services	xcluding Psychiatric Services
Service Category Description	Description
Benefit Description	Description
Topographical Control of the Control	Response
llee 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

through MCS Solutions.	Preauthorization required through MCS Solutions	Notes:
through MCS Solutions.	Preauthorization required through MCS Solutions	Notes:
Contrato Número	No	Is a referral required for Mental Health Specialty Services - Non-Physician?
	Yes	Is authorization required?
4 0 0 0 4	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Group Sessions:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Group Sessions:
OF SURVEY DE SALUD	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:
ADMINISTRACION DE	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:
	No	Is there an enrollee Copayment?
The state of the s	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
The state of the s	Response	Question
	ription	Benefit Description
	Description	Service Category Description
	cialty Services	7e Mental Health Specialty Services
		The second secon

		A result of the state of the st			-
		and the second s			
NO TO THE REAL PROPERTY OF THE PARTY OF THE		Benef	Service Ca	7f Pod	at the property and the second course
	Response	Benefit Description	Service Category Description	7f Podiatry Services	A CONTRACTOR OF THE CONTRACTOR
		and the same of th		イング	

Question

/ I rouldity Selvices	
Service Category Description	n
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 Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	\$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	\$0.00
Indicate Minimum Copayment amount per visit for Routine Foot Care:	\$0,00
Indicate Maximum Copayment amount per visit for Routine Foot Care:	\$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes
Notes:	Routine foot care will be provided in the home by trained foot professionals.

7g Other Health Care Professional Services	Services	
Service Category Description	tion	
Benefit Description		ADMINISTRACION DE
Question	Response	SEGURUS DE SALUD
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	サークラーサイニ
Is there an enrollee Deductible?	No	
Is there an enrollee Copayment?	No	Contrato Número
Is authorization required?	No	

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Is a referral required for Other Health Care Professional Services?	Question	Benefit Description	Service Category Description	7g Other Health Care Professional Services
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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
	No
Is a referral required for Psychiatric Services?	No

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Service Category Description

Benefit Description		•
Question	Response	manufactors of the design of the state of th
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
Is there an enrollee Coinsurance?	No	MINITER ACIDA DE
Is there an enrollee Deductible?	No	SEGUROS DE SALUD
Is there an enrollee Copayment?	No	
Is authorization required?	Yes	24-0004
Is a referral required for Physical Therapy and Speech-Language Pathology Services?	No	100 m

7j Additional Telehealth Benefits	fits
Service Category Description	on
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	n Services
Service Category Description	ription
Benefit Description	
ion	Response
cket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
	No
Is a referral required for Opioid Treatment Program Services?	No
1.00	

Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Question	Benefit Description	Service Category Description	8a Outpatient Diagnostic Procedures, Tests and Lab Services
No	Response	and the same of th	ion	s and Lab Services
Contrato Número	- 1	W24-0004	SEGURGS DE SALUJ	ADMINISTRACION D

オア

8a Outpatient Diagnostic Procedures, Tests and Lab Service	d Lab Services
Service Category Description	
Benefit Description	
Question	Response
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
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

Contrato Número	No	If a member receives multiple services at the same location on the same day, does only the maximum copay apply?
The state of the s	\$0.00	Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:
四24-0004	\$0.00	Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:
	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:
SEGUROS DE SALUD	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:
ADMINISTE ACION D	\$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 other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):
	No	Is there an enrollee Copayment?
	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
managed and Assembly and Assemb	Response	Question
	The second section of the second section is a second section of the second section sec	Benefit Description
		Service Category Description
	ogical Services	8b Outpatient Diagnostic and Therapeutic Radiological Services

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on Outpatient Diagnostic and The apeatic Radiological Service	liological pervices
Service Category Description	
Benefit Description	
Question	Response
authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	YPA

9a Outpatient Hospital Services	
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Capayment?	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

Response SEGUROS DE SALUD

9a Outpatient Hospital Services Service Category Description Benefit Description

Question

№24-0004

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

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

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Three (3) Pint Deductible Waived

Response

Select enhanced benefit:

Question

Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?

Service Category Description

Benefit Description

M24-0004

9d Outpatient Blood Services	
Service Category Description	
Benefit Description	
	Response
í	
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

OF GOACS CE VALLED		
ADMINISTRACION DB	Yes	Is authorization required for non-emergency Medicare services?
	\$0.00	Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:
	\$0.00	Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:
	\$0.00	Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:
	\$0.00	Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:
	No	Is there an enrollee Copayment?
The state of the s	No	Is there an enrollee Deductible?
A ANN AND THE REAL PROPERTY AND THE PARTY AN	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
ę,	Response	Question
The state of the s	A Company of the Comp	Benefit Description
	ón	Service Category Description
		10a Ambulance Services

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Select enhanced benefit:

Question

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

Service Category Description

M24-0004

Contrato Número

**Benefit Description** 

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Response

Plan Approved Health-related Location

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 13i4 - Transportation for Non-Medical Needs.

## 11a Durable Medical Equipment (DME)

## Service Category Description

Question	Response	:
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No	
20	No	CON DE
Is there an enrollee Deductible?	No	ADMINIST RACION DE
Is there an enrollee Copayment?	No	SECONOS DE CAMBOS.
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes	WO 2 / - 0 0 0 A
Is authorization required?	Yes	1 0 0 0 1 7 = 11

	tion			
	allowing man in jumpho , including , including , including a many .	Benefit Description	Service Category Description	11a Durable Medical Equipment (DME
Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.	Response		3	DME)

11b Prosthetics/Medical Supplies	· is
Service Category Description	
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0,00
Indicate Maximum Copayment amount per item for Medicare-covered Prosthetic Devices:	\$0.00
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

11c Diabeti
c Suppli
es and S
ervices a
ind Diab
etic Ther
apeutic :
Shoes or I
Inserts

Service Category Description	3
400	
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 SECTION DE CALLE
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or	\$0.00
Inserts:	

№ 2 4 -- 0 0 0 4

Contrato Número

Service Category Description	
Benefit Description	
	Response
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.

Response
No

Service Category Description  Benefit Description  Benefit Description  Benefit Description  Response  Pes ADMINISTRACION DB  Select enhanced benefit:  Select type of benefit for Number of Treatments:  Mandatory	M2 4 - 0 0 0 4		
Service Category Description  Benefit Description  Response  Jan provide Acupuncture as a supplemental benefit under Part C?  Number of Treatments		Mandatory	Select type of benefit for Number of Treatments:
Service Category Description  Benefit Description  Benefit Description  Response  Jan provide Acupuncture as a supplemental benefit under Part C?  Yes	SEGUROS DE SALUD	Number of Treatments	Select enhanced benefit:
13a Acupuncture Service Category Description Benefit Description	ADMINISTRACION DB	Yes	Does the plan provide Acupuncture as a supplemental benefit under Part C?
13a Acupuncture Service Category Description Benefit Description		Response	Question
13a Acupuncture Service Category Description		otion	Benefit Descri
13a Acupuncture		escription	Service Category D
		ure	13a Acupunci

Contrato Número EM (29/43

13a Acupuncture	ncture
Service Category Description	y Description
Benefit Description	scription
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	ncture

Service Category Description **Benefit Description** Response

Question

Service	13b Ove
Category I	13b Over-the-Counter
Description	r (OTC) Items

	Question	
The state of the Country (OHO) there are a supplemental transfer and or Dark Co		Benefit Description
	Response	The first of the f

13c Meal Benefit

Service Category Description

**Benefit Description** 

Question

Response

ADMINISTRACION DB SEGUROS DE SALUD

№24-0004

13c Meal Benefit	
Service Category Description	
Benefit Description	
	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.	

Question	The statement of the st		9	Question				Question	The management of the state of		
Response	Benefit Description	Service Category Description	13f Other 3	Response	Benefit Description	Service Category Description	13e Other 2	Response	Benefit Description	Service Category Description	13d Other 1
. 5			tin.	The state of the s	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0 G	A CALL COLLEGE COLUMN AND A CALL COLUMN AND A CA	a control of the state of the s		

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Contrato Vitmem	Response	Question
	Benefit Description	The second secon
m24-0004	Service Category Description	
SEGUROS DE SALUL	13i Non-Primarily Health Related Benefits for the Chronically III	
WINITINI I CIVILINI A		
A DATINICTE ACTON D	Response	Question
T. C.	Benefit Description	First St. Comp. 1 de
	Service Category Description	
	13g Dual Eligible SNPs with Highly Integrated Services	

EMR 21/43

Service Category Description
Benefit Description
Respor
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?
Is a referral required?

Does the pla	Question		C	X	Question	200		
Does the plan provide the Annual Physical Exam as a supplemental benefit under Part C?	A. On the same december 1. A man of the same of the sa	Benefit Description	Service Category Description	14b Annual Physical Exam		Benefit Description	Service Category Description	14a Medicare-covered Zero Cost-Sharing Preventive Services
No	Response	3	ription	xam	Response	<b>3</b>	ription	ng Preventive Services
	to the party of th	Andrew to make the color of the		2 2			5	

14c Other Defined Supplemental Benefits	Benefits	
Service Category Description	tion	
Benefit Description		
Question	Response	TA CONTRACTOR CONTRACT
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; 1 Fitness Benefit*; 14c7: Re Web/Phone-based technol Alternative Therapies*; 14	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	ADMINISTRACION DB
Is this benefit unlimited for Nutritional/Dietary Benefit?	No, indicate number	SEGUROS DE SALUD
Indicate number of visits for Nutritional/Dietary Benefit:	0	

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	,	
ノスス	Contrato Námero	Is a referral required for Other Defined Supplemental Benefits?
2	The state of the s	Is authorization required?
	\$0.00	Indicate Maximum Copayment amount for Alternative Therapies:
	\$0,00	Indicate Minimum Copayment amount for Alternative Therapies:
	\$0.00 SEGUROS DE SALUD	Indicate Maximum Copayment amount for Fitness Benefit:
•	\$0.00	Indicate Minimum Copayment amount for Fitness Benefit:
	\$0.00	Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:
	\$0.00	Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:
	\$0.00	Indicate Maximum Copayment amount for Health Education:
	\$0.00	Indicate Minimum Copayment amount for Health Education:
		Is there an enrollee Copayment?
		Is there an enrollee Deductible?
		11s there an enrollee Coinsurance?
	The state of the s	6 there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental No Benefits?
	,	Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental No Benefits?
	Every year	Indicate the number of sessions periodicity:
		Indicate limit for number of sessions
		Is this benefit unlimited?
	Mandatory	Select type of benefit for Therapeutic Massage:
		Indicate number of visits offered for Alternative Therapies:
	No, indicate number	Is this benefit unlimited for Alternative Therapies?
	Mandatory	Select type of benefit for Alternative Therapies:
	Web/Phone-based technologies; Nursing Hotline	Select the type of Remote Access Technologies offered (Select all that apply):
	Mandatory	Select type of benefit for Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline):
	Physical Fitness	Indicate type of Fitness Benefit offered (Select all that apply):
	Mandatory	Select type of benefit for Fitness Benefit:
		Indicate setting for Nutritional/Dietary Benefit:
	Response	Question
		Benefit Description
		Service Category Description
	is .	14c Other Defined Supplemental Benefits

14c Other Defined Supplemental Benefits	nefits
Service Category Description	
Benefit Description	
Question	Response
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.
The apeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.
	The state of the s

# 14d Kidney Disease Education Services

## Service Category Description

OF CALLED		
ECONTRICT RACION DE		
ADMINICATION	No	Is a referral required for Kidney Disease Education Services?
	No	Is authorization required?
	No	Is there an enrollee Copayment?
	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
the same and the s	Response	Question
- parent	scription	Benefit Description

Service Category Description

Benefit Description

Question

Response

Contrato Número

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14e Other Medicare-Covered Preventive Services	ve Services
Service Category Description	5
Benefit Description	
Question	Response
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered Barium Enemas:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Barium Enemas:	\$0,00
Indicate Minimum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered Digital Rectal Exams:	\$0.00
Indicate Minimum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00
Indicate Maximum Copayment amount for Medicare-covered EKG following Welcome Visit:	\$0.00
Is authorization required for Medicare-covered Glaucoma Screening?	No
Is authorization required for Medicare-covered Diabetes Self-Management Training?	No
Is authorization required for Medicare-covered Barium Enemas?	No
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

A P

Question

15 Medicare Part B Rx Drugs and Home Infusion Drugs
Service Category Description
Benefit Description

Response

ADMINISTRACION DB SEGUROS DE SALUD

Contrato Número

SMR

15 Medicare Part B Rx Drugs and Home Infusion Drugs	ifusion 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.	or a Part B rebatable t of the original or that Part B rebatable percentage, MA plans of the total MA plan
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?	ADMINISTRACION DE
Does the plan provide Part D home infusion drugs as part of a bundled service as a mandatory supplemental benefit?	No	SEGUROS DE SALUD
101		

16a Preventive Dental Services (Oral Exams, Prophylaxis (cleaning), Fluoride Treatment, Dental X-Rays) Service Category Description **Benefit Description** Response №24-0004 Contrato Número

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

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

8

Question

SMR

Contrato Número	No	Is there an enrollee Deductible?
	No	Is there an enrollee Coinsurance?
	No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?
	Every year	Select the Maximum Plan Benefit Coverage periodicity:
SEGUROS DE SALOD	1000.00	Indicate Maximum Plan Benefit Coverage amount:
ADMINISTRACION DB	Plan-specified amount per period	Select the Maximum Plan Benefit Coverage type:
	Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?
i i	Yes	Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?
,	Mandatory	Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:
	Yes	Is this benefit unlimited for Extractions?
	Mandatory	Select type of benefit for Extractions:
	Yes	Is this benefit unlimited for Periodontics?
1	Mandatory	Select type of benefit for Periodontics:
	Yes	Is this benefit unlimited for Endodontics?
	Mandatory	Select type of benefit for Endodontics:
1	Every three years	Select the Restorative Services periodicity:
	1	Indicate number of visits for Restorative Services:
	No, indicate number	Is this benefit unlimited for Restorative Services?
The state of the s	Mandatory	Select type of benefit for Restorative Services:
4	Every six months	Select the Diagnostic Services periodicity:
	1	Indicate number of visits for Diagnostic Services:
	No, indicate number	Is this benefit unlimited for Diagnostic Services?
	Mandatory	Select type of benefit for Diagnostic Services:
	Yes	Is this benefit unlimited for Non-routine Services?
	Mandatory	Select type of benefit for Non-routine Services:
Services; Diagnostic Services; Restorative Services; Periodontics; Extractions; Prosthodontics, Other acial Surgery, Other Services	Non-routine Services; Diagnostic Services Endodontics; Periodontics; Extractions; P Oral/Maxillofacial Surgery, Other Services	Select enhanced benefits:
	Yes	Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?
	Response	Question
Market 1 (1) (1) (1) (1) (1) (1) (1) (1) (1) (	The second section of the second section is a second section of the second section sec	Benefit Description
		Service Category Description
		Surgery, Other Services)
ics. Other Oral/Maxillofacial	odontics, Extractions, Prosthodonti	16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Ext Surgery, Other Services)	dontics, Extractions, Prosthodontics, Other Oral/Maxillofacial
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	ADMINISTRACION DE
xams as a suppleme	Yes	SEGUROS DE SALUD
Select enhanced benefit:	Routine Eye Exams	
Select type of benefit for Routine Eye Exams:	Mandatory	124-0004
3		

Contrato Número

SNR

17a Eye Exams	
Service Category Description	
Benefit Description	*
Question	Response
Indicate number of exams for Routine Eye Exams:	<u> </u>
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	escription	
Benefit Description	ption	
Question	Response	The same of the sa
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes	
Select enhanced benefits:	Contact lenses; Eyeglasses (ler Eyeglass frames	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory	as Market
Is this benefit unlimited for Contact lenses?	Yes	
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory	ADMINIST RACION DB
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes	OF GOVOS DE SVEOD
Select type of benefit for Eyeglass lenses:	Mandatory	MO 2 - 000 /
Is this benefit unlimited for Eyeglass lenses?	Yes	1 0 0 0 4
Select type of benefit for Eyeglass frames:	Mandatory	
Is this benefit unlimited for Eyeglass frames?	Yes	Contrato Número

Swo

Response
Plan-specified amount per period
500.00
Every year
1
\$0.00
\$0.00
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.

0.13.0		B. Con. 19
18a Hearing Exams	ns	
Service Category Description	cription	
Benefit Description	on	mm) 113.7 cm m
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	ion for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory	SECTIBOS DE SALTID
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number	OTHER DESIGNATION
Indicate number for Routine Hearing Exams:	1	<b>語24-000</b> /
Select Routine Hearing Exams periodicity:	Еvery year	
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory	Contrato Nice

Contrato Número

EMIC 30/43

18a Hearing Exams	ms
Service Category Description	scription
Benefit Description	ion
Question	Response
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	
Select Fitting/Evaluation for Hearing Aid periodicity:	Еvery 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	11.	
Service Category Description	tion	
Benefit Description	A TOLER TOLER (MANUAL THE TOLER TOLE	of contains and the constitution
	Response	
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes	A DAMAN A CION DE
Select enhanced benefits:	Hearing Aids (all types)	SECTIBOS DE SALLID
or Hearing Aids (all t)	Mandatory	ON ON ON ON ON ON ON
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number	心 4 - 0 0 0 4
Indicate quantity for Hearing Aids (all types):	2	11
Select Hearing Aids (all types) periodicity:	Every year	
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes	Contrato Numero

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18b Hearing Aids	
Service Category Description	on
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:	Ечету уеаг
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.

3			
	44 m m m m m m m m m m m m m m m m m m	1	
			20 Outpa
			tient Drug
		Serv	s and Biol
	Benefit Descriptio	ice Categ	ogicals/Pi
	Benefit Description	Service Category Description	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infusion Drugs
Re		ption	Drugs/H
<b>Response</b>	A STATE OF THE PARTY OF THE PAR		ome Infus
	100000000000000000000000000000000000000		ion Drugs
	V on teament		

Question				Question
	Benefit Description	Service Category Description	20 Outpatient Drugs and Biologicals/Prescription Drugs/Home Infus	Response
Response	ATTENDED TO THE PARTY OF THE PA		gs/Home Infusion Drugs	Response

19a Reduced Cost Sharing for VBID/UF/SSBCI

Response SEGUROS DE SALUD

No M2 4 - 0 0 0 4

Do you offer Special Supplemental Benefits for the Chronically III?

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

Question

	Domination of the state of the
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:	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 VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its borader enrollee population; Identify priority population(s) and associated disparities that will be addressed; Utilize standardized screening tools and/or diagnostic codes to identify and document HRSNs; 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

Question

19b Additional Benefits for VBID/UF/SSBCI

ADMINISTRACION DB SEGUROS DE SALUD.

№ 2 4 - 0 0 0 4

Contrato Número

Contrato Número

Question	Response
art C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	L

	Are any benefits exempt from the plan-level deductible?		4
s 13i10: General Supports for Living; 13i1: 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	Select all the Non-Medicare-covered additional benefits offered in this package:		Que de la companya della companya de
nis No	Is there a prerequisite for any additional benefits for this package?	1	
ses No	Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.		
No	Does the enrollee need to have all diseases selected to qualify?		
ve 3085	Expected Number of Enrollees to be engaged and receive Model benefits:		
3085	Expected Number of Enrollees to be Targeted:		
Dual-Eligible Status (for territories)	Select LIS reduction level:		
Socioeconomic Status	Targeting Methodology - Please choose one or both:		
VBID	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	Additional Benefits for VBID/UF/SSBCI	19b
Response	Question	ion Category	PBP Section
	Benefit Description		
	Service Category Description		
	Disease States:		
Package 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package		

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

M24-00047WM			·
Mandatory	Select type of benefit for Pest Control:		400
ADMINISTRACION DE	Does the plan provide Pest Control as a supplemental Yes benefit under Part C?		
num Plan Ben carries forwa	Notes: Maxim		
	Is a referral required for Food and Produce?	***	4
	Is authorization required?		
	Is there an enrollee Copayment?		
	Is there an enrollee Deductible?		5
	Is there an enrollee Coinsurance?		1
	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?		S
Every month	Select Maximum Plan Benefit Coverage periodicity:		11
150.00	Indicate Maximum Plan Benefit Coverage amount: 15		
	Is there a service-specific Maximum Plan Benefit Coverage Yes amount?	1	
Mandatory	Select type of benefit for Food and Produce:		
	Does the plan provide Food and Produce as a supplemental Yes 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 what type of benefit your Non-Primarily Health Related Benefits for the Chronically III includes: Social Supp	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	19b - 13i
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 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.	Notes:  A VBI Produ need: direct suppl offers (8 vis Gene home		
Response	Question	Category	PBP Section
1.00	Benefit Description		
	Service Category Description		-
	Disease States:		
01	19b Additional Benefits for VBID/UF/SSBCI - VBID Package		

Is there a service-specific Maximum Enrollee Out-of-Pocket No  Cost?  Is there an enrollee Coinsurance?  Is there an enrollee Copayment?  Is authorization required?  No  Is a referral required for Pest Control?  No  Is a referral required for Pest Control?  No  Is a referral required for Pest Control?  No  Does the plan provide Transportation for Non-Medical Needs as a supplemental benefit under Part C?  Select type of benefit of Plan-approved Location:  Select type of benefit of rounber of trips for Plan-approved Location:  Indicate number of trips for Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-Medical Needs for One-way  Plan-approved Location:  Select Mode of Transportation for Non-M
re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? sferral required for Pest Control? ;  sternal required for Pest Control? ;  the plan provide Transportation for Non-Medical as a supplemental benefit under Part C? tenhanced benefit: type of benefit for Plan-approved Location: type of benefit unlimited for number of trips for Planved Location? te number of trips for Plan-approved Location: type of Transportation for Non-Medical Needs for approved Location: type of Transportation for Non-Medical Need for approved Location: type of Transportation for Non-Medical Need for approved Location: ption:
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Copayment? horization required? ferral required for Pest Control? : : : : : : : : : : : : : : : : : : :
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? ferral required for Pest Control? : ferral required for Pest Control? : the plan provide Transportation for Non-Medical as a supplemental benefit under Part C? the plan provide Transportation for Non-Medical benefit unlimited for number of trips for Planved Location: the plan-approved Location Trips periodicity: the number of trips for Plan-approved Location: the plan-approved Location Trips periodicity: the number of Transportation for Non-Medical Needs for approved Location:
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required?  sferral required for Pest Control?  :  :  :  :  :  :  :  :  :  :  :  :  :
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? sferral required for Pest Control? ;  the plan provide Transportation for Non-Medical as a supplemental benefit under Part C? enhanced benefit: type of benefit for Plan-approved Location: benefit unlimited for number of trips for Plan- yed Location? te number of trips for Plan-approved Location:
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? ferral required for Pest Control? : : : : : : : : : : : : : : : : : : :
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? sferral required for Pest Control? ;  the plan provide Transportation for Non-Medical as a supplemental benefit under Part C? tenhanced benefit: type of benefit for Plan-approved Location:
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? sferral required for Pest Control? ; the plan provide Transportation for Non-Medical as a supplemental benefit under Part C? tenhanced benefit:
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? sferral required for Pest Control? :
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? eferral required for Pest Control?
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required? eferral required for Pest Control?
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment? horization required?
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance? re an enrollee Deductible? re an enrollee Copayment?
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance?
re a service-specific Maximum Enrollee Out-of-Pocket re an enrollee Coinsurance?
re a service-specific Maximum Enrollee Out-of-Pocket
Is there a service-specific Maximum Plan Benefit Coverage No amount?
Category Question Response
Benefit Description
Service Category Description
Disease States:
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1

Category	Category		19
Category	Category	Category	ocket No No
Category	Category	Category	
Category	Category	Category	0.00
Category	Category	Category	le Yes
Category	Category	Category	d Manda
Category	Category	Category	Yes
Category	Category	Category	Transportation provided through contracted vendors. Tot trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.
Category	Category	Category	No
Category	Category	Category	8
Category	Category	Category	S
Category	Category	Category	No
Category	Category	Category	8
Category	Category	Category	N.
Category  Question  Select Any Loc: Select Type of Any Location: Select Mode of Any Location: Description:	Category  Question  Select Any Location:  Select Mode of Any Location:  Description:	Category	S
Category  Select Any Location: Select Mode of Any Location:	Category  Question  Select Any Location:  Select Mode of Any Location:  Any Location:	Category	Fleet i
Category	Category	Сатедогу	Van;
Category	Category Question Select Any Location Tri	Category	
Category	Category Question	Сатедогу	Every
	Benefit Description	19b Additional Benefits for VBID/UF/SSBCI - VBID Disease States: Service Category Description Benefit Description	1
Service Category Description		19b Additional Benefits for VBID/UF/SSBCI - VBID	
Disease States: Service Category Description	Disease States:		

					· C		0	111	M								PBP Section Category			
Notes:	Is a referral required for Social Needs Benefit?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	Select Maximum Plan Benefit Coverage periodicity:	Indicate Maximum Plan Benefit Coverage amount:	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Social Needs Benefit:	Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Notes:	Is a referral required for Indoor Air Quality Equipment and Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Question	Service Category Description  Benefit Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package
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	No	No	No No	No Contract Ni	No	et No №2 4 - 0 0 0 4	Every month SEGUROS DE SALUD	0.00 ADMINISTRACION DB	Yes	Mandatory	Yes	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.	No	No	No	No	Response			ackage 1

Disease States:   Service Category Description   Response		Every month Contrato Número	Select Maximum Plan Benefit Coverage periodicity:		
Light Additional Benefits for VBID/UF/SSBCI-VBID Package 1  Disease States:  Service Category Description  Benefit Description  Question  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Naximum Plan Benefit Coverage arount:  Select Maximum Plan Benefit Coverage periodicity:  Every month  Is there an enrollee Consurance?  Notes:  Notes		0.00			
Lategory  Category  Question  Select type of benefit Coverage amount:  Select Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Is there an enrollee Consumance?  Is there an enrollee Coppyment?  Is there an enrollee Coppyment?  Notes:  Does the plan provide Services Supporting Self-Direction as supplemental benefit under Part C?  Notes:  Select type of benefit for Services Supporting Self-Direction:  Select type of benefit for Services Supporting Self-Direction as supplemental benefit or Services Supporting Self-Direction:	-		service-specific Maximum Plan Benefit Coverage		
Disease States:  Service Category Description  Benefit Description  Benefit Coverage arount:  Is there a service-specific Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket  Cost?  Is there an enrollee Colosurance?  Is there an enrollee Colosurance?  Is there an enrollee Colosurance?  No tes:  Is there an enrollee Colopayment?  No Notes::  No Notes::  Notes:  Notes:  Notes::  No No Notes::  No Notes::  No No No Notes::  No No Notes::  No No Notes::  No No No Notes::  No No No Notes::  No No No Notes::  No N	9	atory	Select type of benefit for Services Supporting Self- Direction:		
Disease States:  Service Category Description  Question  Question  Category  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Is there an enrollee Coinsurance?  Is there an enrollee Coinsurance?  Is there an enrollee Copayment?  Is authorization required?  Is a referral required for Complementary Therapies?  Notes:	H		orting Self-Direction as		
Disease States:  Service Category Description  Benefit Description  Category  Question  Question  Category  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies: Mand Is there a service-specific Maximum Plan Benefit Coverage amount: D.00  Select Maximum Plan Benefit Coverage periodicity: Every Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?  Is there an enrollee Copayment?  Is there an enrollee Copayment?  No Is authorization required?  No Is a referral required for Complementary Therapies?  No No		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 prebiotic or probiotic products are also commonly used (NCCIM, 2016a).	Notes:		9
Disease States:  Category  Category  Category  Disease States:  Service Category Description  Benefit Description  Benefit Description  Category  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Select Maximum Plan Benefit Coverage periodicity:  Every  Is there an enrollee Coinsurance?  Is there an enrollee Coinsurance?  Is there an enrollee Copayment?  No  Is authorization required?  No		No	Is a referral required for Complementary Therapies?		
Disease States:  Service Category Description  Category  Question  Does the plan provide Complementary Therapies as a supplemental benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage periodicity:  Select Maximum Plan Benefit Coverage periodicity:  Select Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket No Is there an enrollee Cojnsurance?  No  Is there an enrollee Copayment?  No		No			
Disease States:  Category  Category  Category  Does the plan provide Complementary Therapies as a supplemental benefit Coverage amount?  Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?  Is there an enrollee Coinsurance?  No  Signature States:  Disease States:  Respiblicate Maximum Plan Benefit Coverage periodicity:  Every  Is there an enrollee Coinsurance?  No  No		No	Is there an enrollee Copayment?		
Disease States:   Service Category Description		No	there an enrollee		
Disease States:  Service Category Description  Category  Does the plan provide Complementary Therapies as a supplemental benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Indicate Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?  No Disease States:  Respicate Category Description  Respicate Service Category Description  Respicate Category Description  Respicate Maximum Plan Benefit Coverage amount:  O.00  Select Maximum Plan Benefit Coverage periodicity:  Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?		No	Is there an enrollee Coinsurance?		
Disease States:  Service Category Description  Benefit Description  Category  Question  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage amount:  Indicate Maximum Plan Benefit Coverage periodicity:  Every  Every		No	re a service-specific Maximum Enrollee Out-of-Pocket		
Disease States:   Service Category Description		Every month	Select Maximum Plan Benefit Coverage periodicity:		
Disease States:  Category  Category  Does the plan provide Complementary Therapies as a supplemental benefit for Complementary Therapies:  Select type of benefit for Complementary Therapies:  Is there a service-specific Maximum Plan Benefit Coverage Yes amount?		0.00			
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1  Disease States:  Service Category Description  Benefit Description  Category  Question  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?  Select type of benefit for Complementary Therapies:  Mand		Yes	a service-specific Maximum Plan Benefit Coverage		
Disease States:  Service Category Description  Category  Question  Does the plan provide Complementary Therapies as a supplemental benefit under Part C?		Mandatory	Select type of benefit for Complementary Therapies:		
19b Additional Benefits for VBID/UF/SSBCI - VBID Pack Disease States: Service Category Description Benefit Description Category Question		Yes	ary Therapies as a		
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1  Disease States:  Service Category Description  Benefit Description		Response	Question	į	PBP Sec
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1  Disease States:  Service Category Description		The second secon	Benefit Description		1
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1  Disease States:			Service Category Description		
19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1			Disease States:		
		age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Pack		

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No	Is a referral required for General Supports for Living?		
No	Is authorization required?	b	1
No	Is there an enrollee Copayment?		2
No	Is there an enrollee Deductible?	1	
No	Is there an enrollee Coinsurance?		
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		e m . The man department of the second
No	Is there a service-specific Maximum Plan Benefit Coverage amount?		
Mandatory	Select type of benefit for General Supports for Living:		
Yes	Does the plan provide General Supports for Living as a supplemental benefit under Part C?		i.
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.	Notes:		
NO	Is a referral required for Services Supporting Self- Direction?		
No	Is authorization required?		
No	Is there an enrollee Copayment?		
No	Is there an enrollee Deductible?		
No	Is there an enrollee Coinsurance?		
No	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?		
Response	Question	Category	PBP Section
	Benefit Description	. The same of the	*
	Service Category Description		
	Disease States:		
tkage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package		

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	ic a name of		,	8
	Mandatory	Select type of benefit for Other 2:		-
	Pet care	Enter name of Service:		2
8	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.	Notes:		D
1	No	Is a referral required for Other 1 Services?	A.	
6	No No	Is authorization required?		Part 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1
<b>\</b>	No Contrata Nice	Is there an enrollee Copayment?		
	No	Is there an enrollee Deductible?		
<b>9</b>	No #24-000 4	Is there an enrollee Coinsurance?	THE	
CUL	No SEGUROS DE SALUD	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?		
DE NC	ADMINISTRACION DE	Is there a service-specific Maximum Plan Benefit Coverage amount?		•
	Mandatory	Select type of benefit for Other 1:		
	Home cleaning	Enter name of Service:	Company of the party of the par	
	Other 1; Other 2; Other 3; Other 4	Select what Other type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically III	19b - 13i
, Ab	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.	Notes:		
	Response	Question	Category	PBP Section
	21.	Benefit Description	The second secon	The state of the s
_ ,		Service Category Description		
		Disease States;		
	age 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package		

Contrato Número		
No	Is a referral required for Other 3 Services?	
No M Z 4 - U U U 4	Is authorization required?	
No So A	Is there an enrollee Copayment?	
No SEGUROS DE SALUD	Is there an enrollee Deductible?	
ADMINISTRACION DE	Is there an enrollee Coinsurance?	
No	Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	
Every month	Select Maximum Plan Benefit Coverage periodicity:	
0.00	Indicate Maximum Plan Benefit Coverage amount:	
Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Mandatory	Select type of benefit for Other 3:	
Memory Fitness and Cognitive Function	Enter name of Service:	70
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.	Notes:	
No	Is a referral required for Other 2 Services?	
No	Is authorization required?	
No	Is there an enrollee Copayment?	
No	Is there an enrollee Deductible?	
No	Is there an enrollee Coinsurance?	
No	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?	
Every month	Select Maximum Plan Benefit Coverage periodicity:	
0,00	Indicate Maximum Plan Benefit Coverage amount:	
Yes	Is there a service-specific Maximum Plan Benefit Coverage amount?	
Response	Question	PBP Section Category
	Benefit Description	And the second s
	Service Category Description	
	Disease States:	
rage 1	19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1	

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			1								PBP Section Category	V Autor Various Supple			
								:			7	and the controller			
Notes:	Is a referral required for Other 4 Services?	Is authorization required?	Is there an enrollee Copayment?	Is there an enrollee Deductible?	Is there an enrollee Coinsurance?	Is there a service-specific Maximum Enrollee Out-of-Pocket No Cost?	Is there a service-specific Maximum Plan Benefit Coverage amount?	Select type of benefit for Other 4:	Enter name of Service:	Notes:	Question	Benefit Description	Service Category Description	Disease States:	19b Additional Benefits for VBID/UF/SSBCI - VBID Package
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.	No	No	No	No	No	No	No	Mandatory	Hairstyling	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.	Response	A A A TITLE			kage 1

ADMINISTRACION DE SEGUROS DE SALUD Nº 24-0004

Contrato Número

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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 III: No

Part D Senior Savings Model: No

egion:

Lead Marketing Region:

Org. Marketing Name:

Plan Name:

MCS Classicare Platino Del Sur (HMO D-SNP)

Puerto Rico South 8

Version 2 - Renewal - Successfully exported to desk review

New York MCS Classicare New York

Plan Geographic Name:

Status:

Plan Type: Enrollee Type: Number of Tiers:

Part A and Part B

(06/06/23)

100

US - No

Yes, 00024446 Yes, Defined Standard

V<sub>D</sub>C

Dual-Eligible

Medicare non-zero dollar cost sharing plan

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

Special Needs Plan Type: Dual-Eligible SNP: Part D Benefit:

Formulary:

Special Needs Plan:

Part D Plan Premium:
Continuation Area Available:
Visitor/Travel Benefit Available:

Standard Bid For Section B:

No

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Standard Bid For Section C: Standard Bid For Section D:

0 0 0

	100
\$35.00	Indicate Insulin Copayment amount for Out-of-Network  Pharmacy other day supply:
\$33,00	Pharmacy one month supply:
\$35 NO	Indicate Incidin Consument amount for Out of Notwork
\$105.00	Indicate Insulin Copayment amount for Standard Mail Order
	Cost-Sharing two month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Cost-Sharing one month supply:
	Indicate Insulin Copayment amount for Standard Mail Order
	Sharing three month supply:
\$105.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing two month supply:
\$70.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Sharing one month supply:
\$35.00	Indicate Insulin Copayment amount for Standard Retail Cost-
	Indicate which tiers have insulin drugs (Select all that apply):
Sponsor attests that it will comply with 42 CFR 423.154.	Sponsor attestation
No	Notes Available
Term Care	
Standard Retail; Out-of-Network; Standard Mail-Order; Long-	Pharmacy Network Components
	Utilization Management Program
No	You pay for Over-the-Counter medications (OTCs) under the
	Enrollee Out-of-Pocket Cost Threshold
5030.00	Initial Coverage Limit
25%	Pre-ICL Cost Shares
545.00	Deductible
Plan Data	Benefit
nefit Data	Part D Benefit Data

ADMINISTRACION DE SEGUROS DE SALUD

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	Cost Shares Above the Threshold
formulary model documents.	
vaccines will be designated as such on the beneficiary-facing	3
regardless of tier placement or benefit phase. The applicable	
sales tax, dispensing fee, or vaccine administration fee,	
the prescription drug event (PDE) record, or any associated	
sharing on the ingredient cost of the vaccine submitted on	
Immunization Practices (ACIP). There is no enrollee cost	
adult vaccine recommended by the Advisory Committee on	
I attest that there is no deductible and no cost sharing for an	Vaccine Attestation:
	Pharmacy one month supply:
\$35.0	Indicate Insulin Copayment Amount for Long Term Care

General Data	il 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-	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	e ICL and Cost Shares - Above the Threshold

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VBID - Part D Benefit Data	Benefit Data
Question	Response
Are you offering Part D Benefits and/or Part D Rewards and	No
Incentives under the VBID Model?	
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 SEGUROS DE SALUD

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#### **Bid Reports 2024**

#### Plan Service Area Report

MCS ADVANTAGE, INC.
H5577 - OSS
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:

Plan Type:
Enroller Type:
Part C Plan Premium:
Part D Plan Premium:
Continuation Area Available:
Visitor/Travel Benefit Available:
Formulary:

N 0 0

Standard Bid For Section B: Standard Bid For Section C: Standard Bid For Section D: Part D Benefit:
Special Needs Plant:
Special Needs Plant Type:
Dual-Flighth SNP:
Under this D-SNP, has the state agreed to cover all Medicare
premiums and cost sharing for enrollees in your D-SNP?

State Puerto Rico	Coamo	County Code 40210	No Employer-Only County?	Pending County?	
THE TAY THEY	COUNTY				
Puerto Rico	Guayanilla	40290	N <sub>O</sub>	Ž.	
Puerto Rico	Juana Diaz	-10370	No		No
Puerta Rico	Penuelas	40550	No		No
Puerto lico	Ponce	40560	No		No
Puerto Rico	Salinas	40620	No		No
Puerto Rico	Santa Isabel	40670	No		No

ADMINISTRACION DE SEGUROS DE SALUD Zipcode(s): 00757

#24-00045 WR

Zipcade(s): 00766

ADMINISTRACION DE SEGUROS DE SALUD

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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 III: No

Part D Senior Savings Model: No

Region:

Lead Marketing Region:

Org. Marketing Name: Plan Name:

MCS Classicare Platino Del Sur (HMO D-SNP)

Puerto Rico South 8

New York

New York

MCS Classicare

Plan Geographic Name:

Status: Plan Type:

Enrollee Type:

\$0.00 Part A and Part B

OMH

(06/06/23)

Version 2 - Renewal - Successfully exported to desk review

N/A

US - No

Yes, 00024446

Yes, Defined Standard

Dual-Eligible

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?

Standard Bid For Section B:

Dual-Eligible SNP: Special Needs Plan Type: Part D Benefit:

Formulary:

Special Needs Plan:

Visitor/Travel Benefit Available:

Continuation Area Available:

Part D Plan Premium:

Part C Plan Premium:

Yes Z 0

ADMINISTRACION DE SEGUROS DE SALUD

M24-0004

Standard Bid For Section C: Standard Bid For Section D:

N O

Plan Level Cost 9	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	Yes
Cost?	
Is your In-Network Maximum Enrollee Out-of-Pocket (MOOP) Lower	Lower
Cost at the Lower, Intermediate or Mandatory Level?	
Indicate In-Network Maximum Enrollee Out-of-Pocket Cost	3400.00
Amount:	
Select the benefits that apply to the In-Network Maximum	In-Network Medicare-covered benefits
Enrollee Out-of-Pocket cost:	
Does the In-Network Maximum Enrollee Out-of-Pocket Cost	Yes
apply to all in-Network Medicare-covered plan services?	

ADMINISTRACION DE SEGUROS DE SALUD

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Enro	Cate	Sele
ee Ou	ories t	tall of
t-of-Pc	hat an	the In-
Enrollee Out-of-Pocket Cost amount:	Categories that are INCLUDED in the In-Network Maximum	Select all of the In-Network Medicare-covered Service
ost am	JDED i	rk Me
ount:	n the l	dicare-
	n-Netw	covere
	/ork ™	ed Serv
	laximu	rice
	3	

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; 7l: Additional Telehealth Benefits; 7k: Opioid Treatment Program

Drugs; 16b: Comprehensive Dent Eyewear; 18a: Hearing Exams; 12 Nursing Facility (SNF); 5: Partial Health Services	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: Medicarecovered Zero Dollar Preventive Services; 14d: Kidney Disease Education Services; 14e; 15-2: Medicare Part B Chemotherapy/Radiation Drugs; 15-3: Other Medicare Part B
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	
covered Zero Dollar Preventive Services Education Services; 14e; 15-2: Medicare Chemotherapy/Radiation Drugs; 15-3: Chemotherapy/Radiation Drugs; 16b: Comprehensive Dental; 17a Eyewear; 18a: Hearing Exams; 12: Dialy Nursing Facility (SNF); 5: Partial Hospita Health Services	_
Education Services; 14e; 15-2: Medicare Chemotherapy/Radiation Drugs; 15-3: (Drugs; 16b: Comprehensive Dental; 17a Eyewear; 18a: Hearing Exams; 12: Dialy Nursing Facility (SNF); 5: Partial Hospita Health Services	
Chemotherapy/Radiation Drugs; 15-3: (Drugs; 16b: Comprehensive Dental; 17a Eyewear; 18a: Hearing Exams; 12: Dialy Nursing Facility (SNF); 5: Partial Hospita Health Services	
Drugs; 16b: Comprehensive Dental; 17a Eyewear; 18a: Hearing Exams; 12: Dialy Nursing Facility (SNF); 5: Partial Hospita Health Services	
Eyewear; 18a: Hearing Exams; 12: Dialy Nursing Facility (SNF); 5: Partial Hospita Health Services	_
Nursing Facility (SNF); 5: Partial Hospita Health Services	
Health Services	_

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

Combined Benefits Group L Name: packages you are offering? Do you offer Combined Supplemental Benefits? Question Select the number of Combined Supplemental Benefit Combined Benefits - General Yes 2 Combined Eyewear and Hearing Response

ADMINISTRACION DE SEGUROS DE SALUD

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Select which non-Medicare covered benefits are included in	17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames);
your Combined Supplemental Benefit package:	17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types)
What is your combined supplemental benefits mode of	Other
delivery?	
Other Description:	Combined Eyewear and Hearing Allowance
ited to one or more of the combined	No
supplemental benefits from the package which they must	
select in advance?	
Do you offer Combined Supplemental Benefits with a shared	Yes
maximum plan benefit amount?	
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	10b1: Transportation Services - Plan Approved Health-related
your Combined Supplemental Benefit package:	Location; 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of	Other
delivery?	
Other Description:	Transportation provided by contracted vendors.
Is the enrollee limited to one or more of the combined	No
supplemental benefits from the package which they must	
select in advance?	
ental Benefits with a shared	No
maximum plan benefit amount?	
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 SEGUROS DE SALUD

№24-0004

Contrato Número EMC

#### SUMMARY **WORKSHEET 6 - MA BID**

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1. Maximum Pt B premium buydown amt., per CMS

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

Nº24-0004