APPENDIX C (1)

Medicare Advantage Plan

Benefit Package PBP

MCS Advantage

Appendix C-1

Plan Benefit Package (PBP)

H5577 – 017

EMR

Bid Reports 2024

PBP Benefits Report

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

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

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

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

2 Skilled Nursing Facility (SNF)

Service Category Description

Benefit Description

Question	Response

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

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

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services

Service Category Description

Benefit Description

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

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	34
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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

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

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	4500.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	1000.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Per ear
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices.

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

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

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	26650
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its 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

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	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

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	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
		Select type of benefit for Pest Control:	Mandatory

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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PBP Part D Benefits Report

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

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

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

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

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

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

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Plan Service Area Report

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

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

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State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Adjuntas	40010	No	No	No Zipcode(s): 00601
Puerto Rico	Aguada	40070	No	No	No Zipcode(s): 00602
Puerto Rico	Aguadilla	40030	No	No	No Zipcode(s): 00603; 00604; 00605; 00690
Puerto Rico	Aguas Buenas	40040	No	No	No Zipcode(s): 00703
Puerto Rico	Aibonito	40050	No	No	No Zipcode(s): 00705; 00786
Puerto Rico	Anasco	40060	No	No	No Zipcode(s): 00610; 00670
Puerto Rico	Arecibo	40070	No	No	No Zipcode(s): 00612; 00613; 00614; 00616; 00652; 00688
Puerto Rico	Arroyo	40080	No	No	No Zipcode(s): 00714
Puerto Rico	Barceloneta	40090	No	No	No Zipcode(s): 00617
Puerto Rico	Barranquitas	40100	No	No	No Zipcode(s): 00794
Puerto Rico	Bayamon	40110	No	No	No Zipcode(s): 00934; 00956; 00957; 00958; 00959; 00960; 00961
Puerto Rico	Cabo Rojo	40120	No	No	No Zipcode(s): 00622; 00623
Puerto Rico	Caguas	40130	No	No	No Zipcode(s): 00725; 00726; 00727

Puerto Rico	Camuy	40140	No	No	No Zipcode(s): 00627; 00670
Puerto Rico	Canovanas	40145	No	No	No Zipcode(s): 00729; 00745
Puerto Rico	Carolina	40150	No	No	No Zipcode(s): 00979; 00981; 00982; 00983; 00984; 00985; 00986; 00987; 00988
Puerto Rico	Catano	40160	No	No	No Zipcode(s): 00962; 00963
Puerto Rico	Cayey	40170	No	No	No Zipcode(s): 00736; 00737
Puerto Rico	Ceiba	40180	No	No	No Zipcode(s): 00735; 00742
Puerto Rico	Ciales	40190	No	No	No Zipcode(s): 00638
Puerto Rico	Cidra	40200	No	No	No Zipcode(s): 00739
Puerto Rico	Coamo	40210	No	No	No Zipcode(s): 00769
Puerto Rico	Comerio	40220	No	No	No Zipcode(s): 00782
Puerto Rico	Corozal	40230	No	No	No Zipcode(s): 00783
Puerto Rico	Culebra	40240	No	No	No Zipcode(s): 00775
Puerto Rico	Dorado	40750	No	No	No Zipcode(s): 00646
Puerto Rico	Fajardo	40260	No	No	No Zipcode(s): 00738; 00740
Puerto Rico	Florida	40265	No	No	No Zipcode(s): 00650
Puerto Rico	Guanica	40270	No	No	No Zipcode(s): 00647; 00653
Puerto Rico	Guayama	40280	No	No	No Zipcode(s): 00704; 00784; 00785
Puerto Rico	Guayanilla	40290	No	No	No Zipcode(s): 00656; 00785
Puerto Rico	Guaynabo	40300	No	No	No Zipcode(s): 00934; 00965; 00966; 00968; 00969; 00970; 00971
Puerto Rico	Gurabo	40310	No	No	No Zipcode(s): 00778
Puerto Rico	Hatillo	40320	No	No	No Zipcode(s): 00659
Puerto Rico	Hormigueros	40330	No	No	No Zipcode(s): 00660
Puerto Rico	Humacao	40340	No	No	No Zipcode(s): 00741; 00745; 00791; 00792
Puerto Rico	Isabela	40350	No	No	No Zipcode(s): 00662
Puerto Rico	Jayuya	40360	No	No	No Zipcode(s): 00664
Puerto Rico	Juana Diaz	40370	No	No	No Zipcode(s): 00795

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Puerto Rico	Juncos	40380	No	No	No Zipcode(s): 00777
Puerto Rico	Lajas	40390	No	No	No Zipcode(s): 00667
Puerto Rico	Lares	40400	No	No	No Zipcode(s): 00631; 00669
Puerto Rico	Las Marias	40410	No	No	No Zipcode(s): 00670
Puerto Rico	Las Piedras	40420	No	No	No Zipcode(s): 00771
Puerto Rico	Loiza	40430	No	No	No Zipcode(s): 00772
Puerto Rico	Luquillo	40440	No	No	No Zipcode(s): 00773
Puerto Rico	Manati	40450	No	No	No Zipcode(s): 00674
Puerto Rico	Maricao	40460	No	No	No Zipcode(s): 00606
Puerto Rico	Maunabo	40470	No	No	No Zipcode(s): 00707
Puerto Rico	Mayaguez	40480	No	No	No Zipcode(s): 00680; 00681; 00682
Puerto Rico	Moca	40490	No	No	No Zipcode(s): 00676
Puerto Rico	Morovis	40500	No	No	No Zipcode(s): 00687
Puerto Rico	Naguabo	40510	No	No	No Zipcode(s): 00718; 00744
Puerto Rico	Naranjito	40520	No	No	No Zipcode(s): 00719
Puerto Rico	Orocovis	40530	No	No	No Zipcode(s): 00720
Puerto Rico	Patillas	40540	No	No	No Zipcode(s): 00723
Puerto Rico	Penuelas	40550	No	No	No Zipcode(s): 00624
Puerto Rico	Ponce	40560	No	No	No Zipcode(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732; 00733, 00734; 00780
Puerto Rico	Quebradillas	40570	No	No	No Zipcode(s): 00678
Puerto Rico	Rincon	40580	No	No	No Zipcode(s): 00677
Puerto Rico	Rio Grande	40590	No	No	No Zipcode(s): 00721; 00745
Puerto Rico	Sabana Grande	40610	No	No	No Zipcode(s): 00637
Puerto Rico	Salinas	40620	No	No	No Zipcode(s): 00704; 00751
Puerto Rico	San German	40630	No	No	No Zipcode(s): 00636; 00683

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Puerto Rico	San Juan	40640	No	No	No Zipcode(s): 00901; 00902; 00905; 00906; 00907; 00908; 00909; 00910; 00911; 00912; 00913; 00914; 00915; 00916; 00917; 00918; 00919; 00920; 00921; 00922; 00923; 00924; 00925; 00926; 00927; 00928; 00929; 00930; 00931; 00933; 00935; 00936; 00937; 00938; 00939; 00940; 00955; 00975; 00976; 00979; 00981
Puerto Rico	San Lorenzo	40650	No	No	No Zipcode(s): 00754
Puerto Rico	San Sebastian	40660	No	No	No Zipcode(s): 00685
Puerto Rico	Santa Isabel	40670	No	No	No Zipcode(s): 00757
Puerto Rico	Toa Alta	40680	No	No	No Zipcode(s): 00953; 00954
Puerto Rico	Toa Baja	40690	No	No	No Zipcode(s): 00949; 00950; 00951; 00952
Puerto Rico	Trujillo Alto	40700	No	No	No Zipcode(s): 00976; 00977; 00978
Puerto Rico	Utuado	40710	No	No	No Zipcode(s): 00611; 00641
Puerto Rico	Vega Alta	40720	No	No	No Zipcode(s): 00692; 00694
Puerto Rico	Vega Baja	40730	No	No	No Zipcode(s): 00693; 00694
Puerto Rico	Vieques	40740	No	No	No Zipcode(s): 00765
Puerto Rico	Villalba	40750	No	No	No Zipcode(s): 00766
Puerto Rico	Yabucoa	40760	No	No	No Zipcode(s): 00767
Puerto Rico	Yauco	40770	No	No	No Zipcode(s): 00698

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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 - 017
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

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

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

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

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

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

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

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

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

I. General Information

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

II. Other Information

A. Part B Information		**B. Rebate Allocation for Part B Premium**	
		1. PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$45.00
1. Maximum Pt B premium buydown amt., per CMS	$164.90	2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$45.00

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MCS Advantage

Appendix C-1

Plan Benefit Package (PBP)

H5577 – 029

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Bid Reports 2024

PBP Benefits Report

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

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino MasCa$h (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 4 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

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

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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7h Psychiatric Services

Service Category Description

Benefit Description

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

7i Physical Therapy and Speech-Language Pathology Services

Service Category Description

Benefit Description

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

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

Question	Response
Do you offer an Additional Telehealth benefit for Part B services?	Yes
Select the Medicare-covered benefits that may have Additional Telehealth Benefits available:	7a: Primary Care Physician Services; 7d: Physician Specialist Services; 7e1: Individual Sessions for Mental Health Specialty Services; 7h1: Individual Sessions for Psychiatric Services; 14e2: Diabetes Self-Management Training

7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Additional Telehealth?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	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
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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

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

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	2400.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount.

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

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

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	22965
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your 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

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19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	22965
		Expected Number of Enrollees to be engaged and receive Model benefits:	22965
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	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; 14c4: Fitness Benefit; 13i3: Pest Control
		Are any benefits exempt from the plan-level deductible?	No
		Is there a package level maximum coverage amount?	No

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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19b Additional Benefits for VBID/UF/SSBCI - VBID Package 1 Disease States: Service Category Description Benefit Description			
PBP Section	**Category**	**Question**	**Response**
		Is a referral required for Other 3 Services?	No
		Notes:	Items/services that support memory fitness and cognitive function - table games, card games, crosswords, puzzles, sudoku, chess/checkers, video games, cooking/drawing/painting/language/musical instrument/meditation classes - will be covered through the VBID Benefits Card.
		Enter name of Service:	Hairstyling
		Select type of benefit for Other 4:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	No
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Other 4 Services?	No
		Notes:	Member may choose up to three (3) services per quarter (12 visits annually) of hairstyling which is combined with pest control, home assistance services filed in General Supports for Living, home cleaning, and pet grooming.

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PBP Part D Benefits Report

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

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

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

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

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

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

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Plan Service Area Report

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

Region	New York
Lead Marketing Region	New York
Org Marketing Name	MCS Classicare
Plan Name	MCS Classicare Platino MarCaSh (HMO D-SNP)
Plan Geographic Name	Puerto Rico
Status	Version 4 - Bene Mail - Successfully expected to desk review (06/06/23)
Plan Type	HMO
Enrollee Type	Part A and Part B
Part C Plan Premium	$0.00
Part D Plan Premium	N/A
Contraception Area Available	No
Visitor/Travel Benefit Available	US - No
Formulary	Yes, 00024446
Part D Benefit	Yes, Defined Standard
Special Needs Plan	Yes
Special Needs Plan Type	Dual Eligible
Dual-Eligible SNP	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B	No
Standard Bid For Section C	No
Standard Bid For Section D	No

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Adjuntas	40010	No	No	Yes Zipcode(s): 00601
Puerto Rico	Aguada	40020	No	No	No Zipcode(s): 00602
Puerto Rico	Aguadilla	40030	No	No	Yes Zipcode(s): 00603, 00604, 00605, 00606
Puerto Rico	Aguas Buenas	40040	No	No	No Zipcode(s): 00703
Puerto Rico	Aibonito	40050	No	No	No Zipcode(s): 00705, 00786
Puerto Rico	Anasco	40060	No	No	No Zipcode(s): 00610, 00612
Puerto Rico	Arecibo	40070	No	No	No Zipcode(s): 00612, 00613, 00614, 00616, 00652, 00688
Puerto Rico	Arroyo	40080	No	No	Yes Zipcode(s): 00714
Puerto Rico	Barceloneta	40090	No	No	No Zipcode(s): 00617
Puerto Rico	Barranquitas	40100	No	No	No Zipcode(s): 00794
Puerto Rico	Bayamon	40110	No	No	No Zipcode(s): 00931, 00956, 00957, 00958, 00959, 00960, 00961
Puerto Rico	Cabo Rojo	40120	No	No	No Zipcode(s): 00623, 00647
Puerto Rico	Caguas	40130	No	No	No Zipcode(s): 00725, 00726, 00727
Puerto Rico	Camuy	40140	No	No	No Zipcode(s): 00627, 00628
Puerto Rico	Canovanas	40145	No	No	Yes Zipcode(s): 00729, 00745
Puerto Rico	Carolina	40150	No	No	No Zipcode(s): 00979, 00981, 00982, 00983, 00984, 00985, 00986, 00987, 00988
Puerto Rico	Catano	40160	No	No	No Zipcode(s): 00962, 00963
Puerto Rico	Cayey	40170	No	No	No Zipcode(s): 00736, 00737
Puerto Rico	Ceiba	40180	No	No	No Zipcode(s): 00735, 00741
Puerto Rico	Ciales	40190	No	No	No Zipcode(s): 00638
Puerto Rico	Cidra	40200	No	No	No Zipcode(s): 00739
Puerto Rico	Coamo	40210	No	No	No Zipcode(s): 00769
Puerto Rico	Comerio	40220	No	No	No Zipcode(s): 00782
Puerto Rico	Corozal	40230	No	No	No Zipcode(s): 00783
Puerto Rico	Culebra	40240	No	No	No Zipcode(s): 00775
Puerto Rico	Dorado	40250	No	No	No Zipcode(s): 00646
Puerto Rico	Fajardo	40260	No	No	No Zipcode(s): 00738, 00740
Puerto Rico	Florida	40265	No	No	No Zipcode(s): 00650
Puerto Rico	Guanica	40270	No	No	No Zipcode(s): 00653, 00704
Puerto Rico	Guayama	40280	No	No	No Zipcode(s): 00654, 00784, 00785
Puerto Rico	Guayanilla	40290	No	No	No Zipcode(s): 00656, 00749
Puerto Rico	Guaynabo	40300	No	No	No Zipcode(s): 00934, 00965, 00966, 00968, 00969, 00970, 00971
Puerto Rico	Gurabo	40310	No	No	No Zipcode(s): 00778
Puerto Rico	Hatillo	40320	No	No	No Zipcode(s): 00659

Puerto Rico	Hormigueros	00330	No	No	No Zipcode(s): 00660
Puerto Rico	Humacao	00340	No	No	No Zipcode(s): 00741 00745 00791 00792
Puerto Rico	Isabela	00350	No	No	No Zipcode(s): 00662
Puerto Rico	Jayuya	00360	No	No	No Zipcode(s): 00664
Puerto Rico	Juana Diaz	00370	No	No	No Zipcode(s): 00795
Puerto Rico	Juncos	00380	No	No	No Zipcode(s): 00777
Puerto Rico	Lajas	00390	No	No	No Zipcode(s): 00667
Puerto Rico	Lares	00400	No	No	No Zipcode(s): 00631 00669
Puerto Rico	Las Marias	00410	No	No	No Zipcode(s): 00670
Puerto Rico	Las Piedras	00420	No	No	No Zipcode(s): 00771
Puerto Rico	Loiza	00430	No	No	No Zipcode(s): 00772
Puerto Rico	Luquillo	00440	No	No	No Zipcode(s): 00773
Puerto Rico	Manati	00450	No	No	No Zipcode(s): 00674
Puerto Rico	Maricao	00460	No	No	No Zipcode(s): 00606
Puerto Rico	Maunabo	00470	No	No	No Zipcode(s): 00707
Puerto Rico	Mayaguez	00480	No	No	No Zipcode(s): 00680 00681 00682
Puerto Rico	Moca	00490	No	No	No Zipcode(s): 00676
Puerto Rico	Morovis	00500	No	No	No Zipcode(s): 00687
Puerto Rico	Naguabo	00610	No	No	No Zipcode(s): 00718 00744
Puerto Rico	Naranjito	00620	No	No	No Zipcode(s): 00719
Puerto Rico	Orocovis	00630	No	No	No Zipcode(s): 00720
Puerto Rico	Patillas	00640	No	No	No Zipcode(s): 00723
Puerto Rico	Penuelas	00650	No	No	No Zipcode(s): 00624
Puerto Rico	Ponce	00660	No	No	No Zipcode(s): 00715, 00716, 00717, 00728, 00730, 00731, 00732, 00733, 00734, 00780
Puerto Rico	Quebradillas	00670	No	No	No Zipcode(s): 00678
Puerto Rico	Rincon	00580	No	No	No Zipcode(s): 00677
Puerto Rico	Rio Grande	00590	No	No	No Zipcode(s): 00721, 00745
Puerto Rico	Sabana Grande	00610	No	No	No Zipcode(s): 00637
Puerto Rico	Salinas	00670	No	No	No Zipcode(s): 00704, 00751
Puerto Rico	San German	00680	No	No	No Zipcode(s): 00646, 00683
Puerto Rico	San Juan	00640	No	No	No 7 zipcode(s): 00901, 00902, 00905, 00906, 00907, 00908, 00909, 00910, 00911, 00912, 00913, 00914, 00915, 00916, 00917, 00918, 00919, 00920, 00921, 00922, 00923, 00924, 00925, 00926, 00927, 00928, 00929, 00930, 00931, 00933, 00935, 00936, 00937, 00938, 00939, 00940, 00955, 00965, 00969, 00979, 00988
Puerto Rico	San Lorenzo	00650	No	No	No Zipcode(s): 00754
Puerto Rico	San Sebastian	00685	No	No	No Zipcode(s): 00685
Puerto Rico	Santa Isabel	00670	No	No	No Zipcode(s): 00757
Puerto Rico	Toa Alta	00680	No	No	No Zipcode(s): 00952, 00953
Puerto Rico	Toa Baja	00690	No	No	No Zipcode(s): 00913, 00949, 00951, 00952
Puerto Rico	Trujillo Alto	00700	No	No	No Zipcode(s): 00976, 00977, 00978
Puerto Rico	Utuado	00730	No	No	No Zipcode(s): 00611, 00613
Puerto Rico	Vega Alta	00720	No	No	No Zipcode(s): 00692, 00731
Puerto Rico	Vega Baja	00730	No	No	No Zipcode(s): 00693, 00694
Puerto Rico	Vieques	00740	No	No	No Zipcode(s): 00765
Puerto Rico	Villalba	00750	No	No	No Zipcode(s): 00766
Puerto Rico	Yabucoa	00760	No	No	No Zipcode(s): 00767
Puerto Rico	Yauco	00770	No	No	No Zipcode(s): 00698

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Plan Level Cost Shares and Limits Report

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

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

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

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

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

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

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

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

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WORKSHEET 6 - MA BID
SUMMARY

I. General Information

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

II. Other Information

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

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MCS Advantage

Appendix C-1

Plan Benefit Package (PBP)

H5577 – 046

Bid Reports 2024

PBP Benefits Report

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

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

Plan Level Data	
Question	**Response**

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Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

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

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Podiatrist Services?	Yes

7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

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

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

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

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

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	24
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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

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

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1200.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	700.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	700.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount.

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

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

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Annual Wellness Visit; Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	23641
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its 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

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	23641
		Expected Number of Enrollees to be engaged and receive Model benefits:	23641
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	13i10: General Supports for Living; 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

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

Disease States:

Service Category Description

Benefit Description

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 filed under General Supports for Living, pet grooming, pest control, home cleaning, and hairstyling. The third benefit is Transportation for Non-Medical Needs.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	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
		Select type of benefit for Pest Control:	Mandatory

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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PBP Part D Benefits Report

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

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

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

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

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

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

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Plan Service Area Report

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

Region:	New York
Local Marketing Region	New York
Org. Marketing Name	MCS Classicare
Plan Name:	MCS Classicare Platino Total (HMO D-SNP)
Plan Geographic. Name:	Puerto Rico
Status	Version 3 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium	50.00
Part D Plan Premium	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available	US - No
Formulary:	Yes, 00023446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan	Yes
Special Needs Plan Type	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Aguadilla	40010	No	No	No Zipcode(s): 00603
Puerto Rico	Aguada	40020	No	No	No Zipcode(s): 00602
Puerto Rico	Aguadilla	40030	No	No	No Zipcode(s): 00603, 00604, 00605, 00610
Puerto Rico	Aguas Buenas	40040	No	No	No Zipcode(s): 00703
Puerto Rico	Aibonito	40050	No	No	No Zipcode(s): 00705, 00786
Puerto Rico	Anasco	40060	No	No	No Zipcode(s): 00610, 00670
Puerto Rico	Arecibo	40070	No	No	No Zipcode(s): 00611, 00612, 00614, 00616, 00652, 00688
Puerto Rico	Arroyo	40080	No	No	No Zipcode(s): 00714
Puerto Rico	Barceloneta	40090	No	No	No Zipcode(s): 00617
Puerto Rico	Barranquitas	40100	No	No	No Zipcode(s): 00794
Puerto Rico	Bayamon	40110	No	No	No Zipcode(s): 00924, 00956, 00957, 00958, 00959, 00960, 00961
Puerto Rico	Cabo Rojo	40120	No	No	No Zipcode(s): 00622, 00623
Puerto Rico	Caguas	40130	No	No	No Zipcode(s): 00725, 00726, 00727
Puerto Rico	Camuy	40140	No	No	No Zipcode(s): 00627, 00670
Puerto Rico	Canovanas	40145	No	No	No Zipcode(s): 00729, 00745
Puerto Rico	Carolina	40150	No	No	No Zipcode(s): 00979, 00981, 00982, 00983, 00984, 00985, 00987, 00988
Puerto Rico	Catano	40160	No	No	No Zipcode(s): 00962, 00963
Puerto Rico	Cayey	40170	No	No	No Zipcode(s): 00736, 00737
Puerto Rico	Ceiba	40180	No	No	No Zipcode(s): 00735, 00742
Puerto Rico	Ciales	40190	No	No	No Zipcode(s): 00638
Puerto Rico	Cidra	40200	No	No	No Zipcode(s): 00739
Puerto Rico	Coamo	40210	No	No	No Zipcode(s): 00769
Puerto Rico	Comerio	40220	No	No	No Zipcode(s): 00782
Puerto Rico	Corozal	40230	No	No	No Zipcode(s): 00783
Puerto Rico	Culebra	40240	No	No	No Zipcode(s): 00775
Puerto Rico	Dorado	40250	No	No	No Zipcode(s): 00646
Puerto Rico	Fajardo	40260	No	No	No Zipcode(s): 00738, 00740
Puerto Rico	Florida	40267	No	No	No Zipcode(s): 00650
Puerto Rico	Guanica	40270	No	No	No Zipcode(s): 00647, 00653
Puerto Rico	Guayama	40280	No	No	No Zipcode(s): 00784, 00785, 00741
Puerto Rico	Guayanilla	40290	No	No	No Zipcode(s): 00656, 00780
Puerto Rico	Guaynabo	40300	No	No	No Zipcode(s): 00931, 00965, 00966, 00968, 00969, 00970, 00971
Puerto Rico	Gurabo	40310	No	No	No Zipcode(s): 00778
Puerto Rico	Hatillo	40320	No	No	No Zipcode(s): 00659

Puerto Rico	Hormigueros	40330	No	No	No Zipcode(s): 00660
Puerto Rico	Humacao	40340	No	No	No Zipcode(s): 00741, 00745, 00791, 00795
Puerto Rico	Isabela	40350	No	No	No Zipcode(s): 00662
Puerto Rico	Jayuya	40360	No	No	No Zipcode(s): 00664
Puerto Rico	Juana Diaz	40370	No	No	No Zipcode(s): 00795
Puerto Rico	Juncos	40380	No	No	No Zipcode(s): 00777
Puerto Rico	Lajas	40390	No	No	No Zipcode(s): 00667
Puerto Rico	Lares	40400	No	No	No Zipcode(s): 00631, 00669
Puerto Rico	Las Marias	40410	No	No	No Zipcode(s): 00670
Puerto Rico	Las Piedras	40420	No	No	No Zipcode(s): 00771
Puerto Rico	Loiza	40430	No	No	No Zipcode(s): 00772
Puerto Rico	Luquillo	40440	No	No	No Zipcode(s): 00773
Puerto Rico	Manati	40450	No	No	No Zipcode(s): 00674
Puerto Rico	Maricao	40460	No	No	No Zipcode(s): 00606
Puerto Rico	Maunabo	40470	No	No	No Zipcode(s): 00707
Puerto Rico	Mayaguez	40480	No	No	No Zipcode(s): 00680, 00681, 00682
Puerto Rico	Moca	40490	No	No	No Zipcode(s): 00676
Puerto Rico	Morovis	40500	No	No	No Zipcode(s): 00687
Puerto Rico	Naguabo	40510	No	No	No Zipcode(s): 00718, 00744
Puerto Rico	Naranjito	40520	No	No	No Zipcode(s): 00719
Puerto Rico	Orocovis	40530	No	No	No Zipcode(s): 00720
Puerto Rico	Patillas	40540	No	No	No Zipcode(s): 00723
Puerto Rico	Penuelas	40550	No	No	No Zipcode(s): 00624
Puerto Rico	Ponce	40560	No	No	No Zipcode(s): 00715, 00716, 00717, 00728, 00730, 00731, 00732, 00733, 00734, 00780
Puerto Rico	Quebradillas	40570	No	No	No Zipcode(s): 00678
Puerto Rico	Rincon	40580	No	No	No Zipcode(s): 00677
Puerto Rico	Rio Grande	40590	No	No	No Zipcode(s): 00721, 00745
Puerto Rico	Sabana Grande	40610	No	No	No Zipcode(s): 00637
Puerto Rico	Salinas	40620	No	No	No Zipcode(s): 00704, 00751
Puerto Rico	San German	40630	No	No	No Zipcode(s): 00683, 00683
Puerto Rico	San Juan	40640	No	No	No Zipcode(s): 00501, 00502, 00595, 00906, 00907, 00908, 00909, 00910, 00911, 00912, 00913, 00914, 00915, 00916, 00917, 00918, 00919, 00920, 00921, 00922, 00923, 00924, 00925, 00926, 00927, 00928, 00929, 00930, 00931, 00933, 00935, 00936, 00937, 00938, 00939, 00940, 00955, 00975, 00976, 00979, 00984
Puerto Rico	San Lorenzo	40650	No	No	No Zipcode(s): 00754
Puerto Rico	San Sebastian	40660	No	No	No Zipcode(s): 00685
Puerto Rico	Santa Isabel	40670	No	No	No Zipcode(s): 00757
Puerto Rico	Toa Alta	40680	No	No	No Zipcode(s): 00951, 00954
Puerto Rico	Toa Baja	40690	No	No	No Zipcode(s): 00949, 00950, 00951, 00954
Puerto Rico	Trujillo Alto	40700	No	No	No Zipcode(s): 00926, 00977, 00978
Puerto Rico	Utuado	40710	No	No	No Zipcode(s): 00611, 00641
Puerto Rico	Vega Alta	40720	No	No	No Zipcode(s): 00692, 00694
Puerto Rico	Vega Baja	40730	No	No	No Zipcode(s): 00693, 00694
Puerto Rico	Vieques	40740	No	No	No Zipcode(s): 00765
Puerto Rico	Villalba	40750	No	No	No Zipcode(s): 00766
Puerto Rico	Yabucoa	40760	No	No	No Zipcode(s): 00767
Puerto Rico	Yauco	40770	No	No	No Zipcode(s): 00698

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Plan Level Cost Shares and Limits Report

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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

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

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

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

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

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

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WORKSHEET 6 - MA BID
SUMMARY

I. General Information

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

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
1 Maximum Pt B premium buydown amt per CMS	$164.90	1 PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$0.00
		2. Part B Rebate Allocation rounded to one decimal (see instructions)	$0.00

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MCS Advantage

Appendix C-1

Plan Benefit Package (PBP)

H5577 – 054

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EMR

Bid Reports 2024

PBP Benefits Report

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

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	1
Segment Geographic Name:	Region 1
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

Plan Level Data	
Question	**Response**

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Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

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

3 Cardiac and Pulmonary Rehabilitation Services

Service Category Description

Benefit Description

Question	Response

4a Emergency Services

Service Category Description

Benefit Description

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

4a Emergency Services

Service Category Description

Benefit Description

Question	Response

4b Urgently Needed Services

Service Category Description

Benefit Description

Question	Response

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory .
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

7f Podiatry Services

Service Category Description

Benefit Description

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

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

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

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

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

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7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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10b Transportation Services Service Category Description Benefit Description	
Question	**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 Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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EMR

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	600.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount.

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

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

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	1139
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its 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

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	1139
		Expected Number of Enrollees to be engaged and receive Model benefits:	1139
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

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Service Category Description

Benefit Description

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

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EMR

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

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Bid Reports 2024

PBP Benefits Report

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

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

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

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

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services

Service Category Description

Benefit Description

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

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

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

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

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

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7j Additional Telehealth Benefits Service Category Description Benefit Description	
Question	**Response**
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required for Additional Telehealth Benefits?	No
Is a referral required for Additional Telehealth Benefits?	No

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Diagnostic Procedures/Tests:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Lab Services:	$0.00

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

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9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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10b Transportation Services Service Category Description Benefit Description	
Question	**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 Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

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

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14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	600.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount.

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

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

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19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	3026
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your VBID HEP. (Select all that apply):	Plan to stratify measures and outcomes to compare and contrast populations and health disparities within its 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

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	3026
		Expected Number of Enrollees to be engaged and receive Model benefits:	3026
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	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

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	180.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	No
		Notes:	Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
		Select type of benefit for Pest Control:	Mandatory

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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Bid Reports 2024

PBP Benefits Report

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

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

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

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

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services

Service Category Description

Benefit Description

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

7g Other Health Care Professional Services

Service Category Description

Benefit Description

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

7h Psychiatric Services

Service Category Description

Benefit Description

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

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

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

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

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7j Additional Telehealth Benefits

Service Category Description

Benefit Description

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

7k Opioid Treatment Program Services

Service Category Description

Benefit Description

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

8a Outpatient Diagnostic Procedures, Tests and Lab Services

Service Category Description

Benefit Description

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

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
Question	**Response**
Indicate Maximum Copayment amount for Medicare-covered Lab Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic Procedures/Test/Lab Services?	Yes

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

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10a Ambulance Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate the Minimum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate the Maximum Copayment amount for Medicare-covered Ground Ambulance Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Air Ambulance Services:	$0.00
Is authorization required for non-emergency Medicare services?	Yes

10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No

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10b Transportation Services Service Category Description Benefit Description	
Question	**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 Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00
Do you limit Diabetic Supplies and Services to those from specified manufacturers?	Yes
Is authorization required?	Yes
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

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13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

14c Other Defined Supplemental Benefits Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount for Other Defined Supplemental Benefits?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Defined Supplemental Benefits?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Health Education:	$0.00
Indicate Maximum Copayment amount for Health Education:	$0.00
Indicate Minimum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Maximum Copayment amount for Nutritional/Dietary Benefit:	$0.00
Indicate Minimum Copayment amount for Fitness Benefit:	$0.00
Indicate Maximum Copayment amount for Fitness Benefit:	$0.00
Indicate Minimum Copayment amount for Alternative Therapies:	$0.00
Indicate Maximum Copayment amount for Alternative Therapies:	$0.00
Is authorization required?	No
Is a referral required for Other Defined Supplemental Benefits?	No
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed dietitian according to patient's health needs, including exercise suggestions.
Fitness Benefit Notes:*	Exercise and Nutrition Education Interventions. Member has access to fitness classes to promote physical activity and a healthier lifestyle.
Remote Access Technology (Web/Phone-based technologies) Notes:*	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Remote Access Technologies (Nursing Hotline) Notes:	Video doctor visits are intended to complement face-to-face visits with a board-certified physician to treat the most common conditions, such as allergies, flu, among others.Nursing Hotline.
Alternative Therapies Notes:*	Foot reflexology is limited to six (6) visits per year and must be ordered by a physician or medical professional.
Therapeutic Massage Notes:	Therapeutic Massage must be ordered by a physician or medical professional.

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14d Kidney Disease Education Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Kidney Disease Education Services?	No

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost for Other Medicare-covered Preventive Services?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Glaucoma Screening:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Diabetes Self-Management Training:	$0.00
Indicate 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

14e Other Medicare-Covered Preventive Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required for Medicare-covered Digital Rectal Exams?	No
Is authorization required for Medicare-covered EKG following Welcome Visit?	No
Is a referral required for any Services?	No

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

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

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes

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16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

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

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	600.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

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

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

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

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.

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

Service Category Description

Benefit Description

Question	Response

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

Service Category Description

Benefit Description

Question	Response

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No
Are you offering a VBID Hospice Benefit?	No
Are you offering Part C benefits under the VBID Model? (VBID Part D Rewards and Incentives programs should be entered in Section Rx)	Yes
In addition to wellness and health care planning, what other interventions have you been approved by CMMI to offer?	Value-Based Design Flexibilities by Condition or Socioeconomic Status
WHP Program Type (choose one or more):	Medicare Health Risk Assessment
WHP Mode of Engagement (choose one or more):	Telephonic; In-Person; Web-Based
Does your organization offer Part C Rewards or Incentives for beneficiaries for the offer of WHP Services?	No
Does your organization offer provider incentives for offering or engaging beneficiaries in WHP activities?	No
Program Connectedness: Please check the way that advance care plans and/or advance directives are connected from your program to access points of care.	Provider/Patient portals
Expected Number of Beneficiaries to be Engaged Annually:	5168
Identify data sources you plan to use to identify disparities in access, outcomes and/or enrollee experience. (Select all that apply):	Internal data sources; External data sources; Patient feedback; Provider feedback; Other, Describe
Identify actions within your 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

19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	5168
		Expected Number of Enrollees to be engaged and receive Model benefits:	5168
		Does the enrollee need to have all diseases selected to qualify?	No
		Does the enrollee need to have a combination of diseases selected to qualify? If yes, describe in notes.	No
		Is there a prerequisite for any additional benefits for this package?	No
		Select all the Non-Medicare-covered additional benefits offered in this package:	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

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	160.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	No
		Notes:	Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

EMR

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

Disease States:

Service Category Description

Benefit Description

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

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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PBP Part D Benefits Report

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

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	1
Segment Geographic Name:	Region 1
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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PBP Part D Benefits Report

MCS ADVANTAGE, INC.
H5577 - 054 2
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	2
Segment Geographic Name:	Region 2
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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Contrato Número

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Bid Reports 2024

PBP Part D Benefits Report

MCS ADVANTAGE, INC.
H5577 - 054 3
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	3
Segment Geographic Name:	Region 3
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan

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

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

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

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

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

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Bid Reports 2024

Plan Service Area Report

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

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	1
Segment Geographic Name:	Region 1
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Aguada	40020	No	No	No Zipcode(s): 00602
Puerto Rico	Aguadilla	40030	No	No	No Zipcode(s): 00603; 00604; 00605; 00690
Puerto Rico	Anasco	40060	No	No	No Zipcode(s): 00610; 00670
Puerto Rico	Arecibo	40070	No	No	No Zipcode(s): 00612; 00613; 00614; 00616; 00652; 00688
Puerto Rico	Camuy	40140	No	No	No Zipcode(s): 00627; 00670

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

ADMINISTRACION DE SEGUROS DE SALUD

№ 2 4 - 0 0 0 4

Contrato Número

Bid Reports 2024

Plan Service Area Report

MCS ADVANTAGE, INC.
H5577 - 054 2
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

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

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

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Puerto Rico	Corozal	40230	No	No	No Zipcode(s): 00783
Puerto Rico	Florida	40265	No	No	No Zipcode(s): 00650
Puerto Rico	Guanica	40270	No	No	No Zipcode(s): 00647; 00653
Puerto Rico	Hormigueros	40330	No	No	No Zipcode(s): 00660
Puerto Rico	Jayuya	40360	No	No	No Zipcode(s): 00664
Puerto Rico	Lajas	40390	No	No	No Zipcode(s): 00667
Puerto Rico	Lares	40400	No	No	No Zipcode(s): 00631; 00669
Puerto Rico	Las Marias	40410	No	No	No Zipcode(s): 00670
Puerto Rico	Manati	40450	No	No	No Zipcode(s): 00674
Puerto Rico	Maricao	40460	No	No	No Zipcode(s): 00606
Puerto Rico	Morovis	40500	No	No	No Zipcode(s): 00687
Puerto Rico	Orocovis	40530	No	No	No Zipcode(s): 00720
Puerto Rico	Sabana Grande	40610	No	No	No Zipcode(s): 00637
Puerto Rico	San German	40630	No	No	No Zipcode(s): 00636; 00683
Puerto Rico	Vega Alta	40720	No	No	No Zipcode(s): 00692; 00694
Puerto Rico	Vega Baja	40730	No	No	No Zipcode(s): 00693; 00694
Puerto Rico	Yauco	40770	No	No	No Zipcode(s): 00698

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Plan Service Area Report

MCS ADVANTAGE, INC.
H5577 - 054 3
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

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

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

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Puerto Rico	Bayamon	40110	No	No	No Zipcode(s): 00934; 00956; 00957; 00958; 00959; 00960; 00961
Puerto Rico	Caguas	40130	No	No	No Zipcode(s): 00725; 00726; 00727
Puerto Rico	Canovanas	40145	No	No	No Zipcode(s): 00729; 00745
Puerto Rico	Carolina	40150	No	No	No Zipcode(s): 00979; 00981; 00982; 00983; 00984; 00985; 00986; 00987; 00988
Puerto Rico	Catano	40160	No	No	No Zipcode(s): 00962; 00963
Puerto Rico	Cayey	40170	No	No	No Zipcode(s): 00736; 00737
Puerto Rico	Ceiba	40180	No	No	No Zipcode(s): 00735; 00742
Puerto Rico	Cidra	40200	No	No	No Zipcode(s): 00739
Puerto Rico	Coamo	40210	No	No	No Zipcode(s): 00769
Puerto Rico	Comerio	40220	No	No	No Zipcode(s): 00782
Puerto Rico	Culebra	40240	No	No	No Zipcode(s): 00775
Puerto Rico	Dorado	40250	No	No	No Zipcode(s): 00646
Puerto Rico	Fajardo	40260	No	No	No Zipcode(s): 00738; 00740
Puerto Rico	Guayama	40280	No	No	No Zipcode(s): 00704; 00784; 00785
Puerto Rico	Guayanilla	40290	No	No	No Zipcode(s): 00656; 00785
Puerto Rico	Guaynabo	40300	No	No	No Zipcode(s): 00934; 00965; 00966; 00968; 00969; 00970; 00971
Puerto Rico	Gurabo	40310	No	No	No Zipcode(s): 00778
Puerto Rico	Humacao	40340	No	No	No Zipcode(s): 00741; 00745; 00791; 00792

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Puerto Rico	Juana Diaz	40370	No	No	No Zipcode(s): 00795
Puerto Rico	Juncos	40380	No	No	No Zipcode(s): 00777
Puerto Rico	Las Piedras	40420	No	No	No Zipcode(s): 00771
Puerto Rico	Loiza	40430	No	No	No Zipcode(s): 00772
Puerto Rico	Luquillo	40440	No	No	No Zipcode(s): 00773
Puerto Rico	Maunabo	40470	No	No	No Zipcode(s): 00707
Puerto Rico	Naguabo	40510	No	No	No Zipcode(s): 00718; 00744
Puerto Rico	Naranjito	40520	No	No	No Zipcode(s): 00719
Puerto Rico	Patillas	40540	No	No	No Zipcode(s): 00723
Puerto Rico	Penuelas	40550	No	No	No Zipcode(s): 00624
Puerto Rico	Ponce	40560	No	No	No Zipcode(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732; 00733; 00734; 00780
Puerto Rico	Rio Grande	40590	No	No	No Zipcode(s): 00721; 00745
Puerto Rico	Salinas	40620	No	No	No Zipcode(s): 00704; 00751
Puerto Rico	San Juan	40640	No	No	No Zipcode(s): 00901; 00902; 00905; 00906; 00907; 00908; 00909; 00910; 00911; 00912; 00913; 00914; 00915; 00916; 00917; 00918; 00919; 00920; 00921; 00922; 00923; 00924; 00925; 00926; 00927; 00928; 00929; 00930; 00931; 00933; 00935; 00936; 00937; 00938; 00939; 00940; 00955; 00975; 00976; 00979; 00981
Puerto Rico	San Lorenzo	40650	No	No	No Zipcode(s): 00754
Puerto Rico	Santa Isabel	40670	No	No	No Zipcode(s): 00757
Puerto Rico	Toa Alta	40680	No	No	No Zipcode(s): 00953; 00954

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Puerto Rico	Toa Baja	40690	No	No	No Zipcode(s): 00949; 00950; 00951; 00952
Puerto Rico	Trujillo Alto	40700	No	No	No Zipcode(s): 00976; 00977; 00978
Puerto Rico	Vieques	40740	No	No	No Zipcode(s): 00765
Puerto Rico	Villalba	40750	No	No	No Zipcode(s): 00766
Puerto Rico	Yabucoa	40760	No	No	No Zipcode(s): 00767

EMR

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SEGUROS DE SALUD

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Contrato Número

Bid Reports 2024

Plan Level Cost Shares and Limits Report

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

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	1
Segment Geographic Name:	Region 1
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan

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

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

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

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

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

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Contrato Número

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

ADMINISTRACION DE SEGUROS DE SALUD

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Bid Reports 2024

Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.
H5577 - 054 - 2
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

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

ADMINISTRACION DE SEGUROS DE SALUD

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

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

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

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

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

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

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Bid Reports 2024

Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.
H5577 - 054 - 3
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)
Plan Geographic Name:	Puerto Rico
Segment ID:	3
Segment Geographic Name:	Region 3
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan

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

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

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ADMINISTRACION DE SEGUROS DE SALUD

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

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

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

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

ADMINISTRACION DE SEGUROS DE SALUD

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WORKSHEET 6 - MA BID SUMMARY

I. General Information

1. Contract Number:	H5577	5. Organization Name:	MCS ADVANTAGE, INC.	9. Enrollee Type:	A/B	13. Region Name:
2. Plan ID:	054	6. Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)	10. MA Region:	N/A	
3. Segment ID:	001	7. Plan Type:	HMO	11. Act. Swap/Equiv Apply:	N	
4. Contract Year:	2024	8. MA-PD:	Y	12. SNP:	Y	14. SNP Type:

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
		1. PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$100.00
1. Maximum Pt B premium buydown amt., per CMS	$164.90	2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$100.00

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WORKSHEET 6 - MA BID SUMMARY

I. General Information

1. Contract Number:	H5577	5. Organization Name:	MCS ADVANTAGE, INC.	9. Enrollee Type:	A/B	13. Region Name:
2. Plan ID:	054	6. Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)	10. MA Region:	N/A	
3. Segment ID:	002	7. Plan Type:	HMO	11. Act. Swap/Equiv Apply:	N	
4. Contract Year:	2024	8. MA-PD:	Y	12. SNP:	Y	14. SNP Type:

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
1. Maximum Pt B premium buydown amt., per CMS	$164.90	1. PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$100.00
		2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$100.00

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WORKSHEET 6 - MA BID SUMMARY

I. General Information

1. Contract Number:	H5577	5. Organization Name:	MCS ADVANTAGE, INC.	9. Enrollee Type:	A/B	13. Region Name:
2. Plan ID:	054	6. Plan Name:	MCS Classicare Platino Maximo (HMO D-SNP)	10. MA Region:	N/A	
3. Segment ID:	003	7. Plan Type:	HMO	11. Act. Swap/Equiv Apply:	N	
4. Contract Year:	2024	8. MA-PD:	Y	12. SNP:	Y	14. SNP Type:

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
1. Maximum Pt B premium buydown amt., per CMS	$164.90	1. PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$100.00
		2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$100.00

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MCS Advantage

Appendix C-1

Plan Benefit Package (PBP)

H5577 – 055

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Bid Reports 2024

PBP Benefits Report

MCS ADVANTAGE, INC.
H5577 - 055
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Del Sur (HMO D-SNP)
Plan Geographic Name:	Puerto Rico South 8
Segment ID:	0
Segment Geographic Name:	null
Status:	**Version 2 - Renewal - Successfully exported to desk review (06/06/23)**
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	**$0.00**
Part D Plan Premium:	**N/A**
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

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Plan Level Data	
Question	**Response**

Tiered Cost sharing for Part B Services	
Question	**Response**
Do any of your outpatient services have tiered cost sharing? (Please note: Inpatient Hospital services that have tiered cost sharing are entered in Section B of the PBP software)	No

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

1a Inpatient Hospital-Acute Service Category Description Benefit Description	
Question	**Response**

1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Inpatient Hospital Psychiatric Services as a supplemental benefit under Part C?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No

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1b Inpatient Hospital-Psychiatric Service Category Description Benefit Description	
Question	**Response**
Does this plan's Medicare-covered benefit cost sharing vary by hospital(s) in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
What is your Inpatient Hospital Psychiatric benefit period?	Original Medicare
Is authorization required?	Yes
Is a referral required for Inpatient Psychiatric Hospital Services?	No
Notes:	Preauthorization required through MCS Solutions, except for Emergency and Urgency Services.

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

2 Skilled Nursing Facility (SNF) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Skilled Nursing Facility Services as a supplemental benefit under Part C?	No
Do you allow less than 3 day inpatient hospital stay prior to SNF admission?	Yes
Indicate the Number of Hospital Days Required Prior to SNF Admission (0-2):	Zero
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Does this plan's Medicare-covered benefit cost sharing vary by the Skilled Nursing Facility in which an enrollee obtains care?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
What is your SNF benefit period?	Original Medicare

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

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

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

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

3 Cardiac and Pulmonary Rehabilitation Services Service Category Description Benefit Description	
Question	**Response**

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

4a Emergency Services Service Category Description Benefit Description	
Question	**Response**

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

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

4c Worldwide Emergency/Urgent Coverage Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Worldwide Emergency/Urgent Coverage as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Worldwide Emergency Coverage; Worldwide Urgent Coverage
Select type of benefit for Worldwide Emergency Coverage:	Mandatory
Select type of benefit for Worldwide Urgent Coverage:	Mandatory
Is there a Maximum Plan Benefit Coverage amount for Worldwide Emergency/Urgent Coverage?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Emergency Coverage:	$0.00
Indicate Minimum Copayment amount for Worldwide Urgent Coverage:	$0.00
Indicate Maximum Copayment amount for Worldwide Urgent Coverage:	$0.00
Is there an enrollee Deductible?	No
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.
Notes:	Coverage is managed through reimbursement based on different fee schedules allowed by our plan, less applicable member cost share.

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

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

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

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7b Chiropractic Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Chiropractic Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Care
Select type of benefit for Routine Care:	Mandatory
Is this benefit unlimited for Routine Care?	No, indicate number
Indicate number of visits for Routine Care:	6
Select Routine Care periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount per visit for Routine Care:	$0.00
Indicate Maximum Copayment amount per visit for Routine Care:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Chiropractic Services?	Yes

7c Occupational Therapy Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	Yes
Is a referral required for Occupational Therapy Services?	No

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

7e Mental Health Specialty Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	Yes
Is a referral required for Mental Health Specialty Services - Non-Physician?	No
Notes:	Preauthorization required through MCS Solutions.
Notes:	Preauthorization required through MCS Solutions.

7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**

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7f Podiatry Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Podiatry Services as a supplemental benefit under Part C?	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 Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No

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7g Other Health Care Professional Services Service Category Description Benefit Description	
Question	**Response**
Is a referral required for Other Health Care Professional Services?	Yes

7h Psychiatric Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Individual Sessions:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Group Sessions:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Group Sessions:	$0.00
Is authorization required?	No
Is a referral required for Psychiatric Services?	No

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

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

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

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

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8a Outpatient Diagnostic Procedures, Tests and Lab Services Service Category Description Benefit Description	
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

8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Maximum Copayment amount for other Medicare-covered Diagnostic Radiological Services (e.g., CT, MRI, etc):	$0.00
Indicate Minimum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Therapeutic Radiological Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered X-Ray Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered X-Ray Services:	$0.00
If a member receives multiple services at the same location on the same day, does only the maximum copay apply?	No

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8b Outpatient Diagnostic and Therapeutic Radiological Services Service Category Description Benefit Description	
Question	**Response**
Is authorization required?	Yes
Is a referral required for Outpatient Diagnostic/Therapeutic Radiological, and X-Ray Services?	Yes

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Maximum Copayment amount per visit for Medicare-covered Outpatient Hospital Services:	$0.00
Indicate Minimum Copayment amount for Medicare-covered Observation Services:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Observation Services:	$0.00
Is authorization required for Medicare-covered Outpatient Hospital Services?	Yes
Is authorization required for Medicare-covered Observation Services?	No
Is a referral required for Medicare-covered Outpatient Hospital Services?	Yes
Is a referral required for Medicare-covered Observation Services?	No

9a Outpatient Hospital Services Service Category Description Benefit Description	
Question	**Response**

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

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

9d Outpatient Blood Services Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Outpatient Blood Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Three (3) Pint Deductible Waived

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9d Outpatient Blood Services

Service Category Description

Benefit Description

Question	Response
Select type of benefit for Three (3) Pint Deductible Waived:	Mandatory
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Outpatient Blood Services?	No

10a Ambulance Services

Service Category Description

Benefit Description

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

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10b Transportation Services

Service Category Description

Benefit Description

Question	Response
Does the plan provide Transportation Services as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Plan Approved Health-related Location

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10b Transportation Services Service Category Description Benefit Description	
Question	**Response**
Select type of benefit for Plan Approved Health-related Location:	Mandatory
Is this benefit unlimited for number of trips for Plan Approved Health-related Location?	No
Indicate number of trips for Plan Approved Health-related Location:	12
Select Plan Approved Health-related Location Trips periodicity:	Every year
Select Type of Transportation for Plan Approved Health-related Location:	One-way
Select Mode of Transportation for Plan Approved Health-related Location:	Medical Transport; Other, Describe
Description:	Fleet includes sedans, minivans, buses with hydraulic ramps.
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Transportation Services?	No
Notes:	Transportation provided through contracted vendors. Total trips are a combination of 10b - Transportation for HRNs, and 13i4 - Transportation for Non-Medical Needs.

11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Are there preferred vendors/manufacturers for Durable Medical Equipment (DME)?	Yes
Is authorization required?	Yes

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11a Durable Medical Equipment (DME) Service Category Description Benefit Description	
Question	**Response**
Notes:	Pre-authorization by PCP (for corresponding services) is managed through Referral/Authorization Form.

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

11c Diabetic Supplies and Services and Diabetic Therapeutic Shoes or Inserts Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Maximum Copayment amount per item for Medicare-covered Diabetes Supplies:	$0.00
Indicate Minimum Copayment amount per item for Medicare-covered Diabetic Therapeutic Shoes or Inserts:	$0.00

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

12 Dialysis Services Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Dialysis Services?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Acupuncture as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Number of Treatments
Select type of benefit for Number of Treatments:	Mandatory

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13a Acupuncture Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Number of Treatments?	No
Indicate limit for Number of Treatments:	6
Indicate Number of Treatments periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Is authorization required?	No
Is a referral required for Acupuncture?	No

13a Acupuncture Service Category Description Benefit Description	
Question	**Response**

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

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**

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Contrato Número EMR

13c Meal Benefit Service Category Description Benefit Description	
Question	**Response**
Does the plan provide a limited duration Meal Benefit as a supplemental benefit under Part C? Note: Only primarily health-related meals offered in accordance with Chapter 4 of the MMCM should be entered in this section.	No

13d Other 1 Service Category Description Benefit Description	
Question	**Response**

13e Other 2 Service Category Description Benefit Description	
Question	**Response**

13f Other 3 Service Category Description Benefit Description	
Question	**Response**

13g Dual Eligible SNPs with Highly Integrated Services Service Category Description Benefit Description	
Question	**Response**

13i Non-Primarily Health Related Benefits for the Chronically Ill Service Category Description Benefit Description	
Question	**Response**

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14a Medicare-covered Zero Cost-Sharing Preventive Services Service Category Description Benefit Description	
Question	**Response**
Medicare-covered Zero Dollar Preventive Services Attestation	I attest that there is no coinsurance, copayment, or deductible for all Original Medicare preventive services that are offered at zero dollar cost sharing.
Is authorization required?	No
Is a referral required?	No

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

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

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

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

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14c Other Defined Supplemental Benefits

Service Category Description

Benefit Description

Question	Response
Nutritional/Dietary Benefit Notes:	Personal evaluation and diet plan designed by licensed 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

Service Category Description

Benefit Description

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

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14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

Question	Response

14e Other Medicare-Covered Preventive Services

Service Category Description

Benefit Description

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

15 Medicare Part B Rx Drugs and Home Infusion Drugs

Service Category Description

Benefit Description

Question	Response

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

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Contrato Número

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

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

EMR

16b Comprehensive Dental Services (Non-Routine, Diagnostic, Restorative, Endodontics, Periodontics, Extractions, Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services) Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Comprehensive Dental Items as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Non-routine Services; Diagnostic Services; Restorative Services; Endodontics; Periodontics; Extractions; Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services
Select type of benefit for Non-routine Services:	Mandatory
Is this benefit unlimited for Non-routine Services?	Yes
Select type of benefit for Diagnostic Services:	Mandatory
Is this benefit unlimited for Diagnostic Services?	No, indicate number
Indicate number of visits for Diagnostic Services:	1
Select the Diagnostic Services periodicity:	Every six months
Select type of benefit for Restorative Services:	Mandatory
Is this benefit unlimited for Restorative Services?	No, indicate number
Indicate number of visits for Restorative Services:	1
Select the Restorative Services periodicity:	Every three years
Select type of benefit for Endodontics:	Mandatory
Is this benefit unlimited for Endodontics?	Yes
Select type of benefit for Periodontics:	Mandatory
Is this benefit unlimited for Periodontics?	Yes
Select type of benefit for Extractions:	Mandatory
Is this benefit unlimited for Extractions?	Yes
Select type of benefit for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	Mandatory
Is this benefit unlimited for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services?	Yes
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	1000.00
Select the Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No

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

Service Category Description

Benefit Description

Question	Response
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Non-routine Services:	$0.00
Indicate Maximum Copayment amount for Non-routine Services:	$0.00
Indicate Minimum Copayment amount for Restorative Services:	$0.00
Indicate Maximum Copayment amount for Restorative Services:	$0.00
Indicate Minimum Copayment amount for Endodontics:	$0.00
Indicate Maximum Copayment amount for Endodontics:	$0.00
Indicate Minimum Copayment amount for Periodontics:	$0.00
Indicate Maximum Copayment amount for Periodontics:	$0.00
Indicate Minimum Copayment amount for Extractions:	$0.00
Indicate Maximum Copayment amount for Extractions:	$0.00
Indicate Minimum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Indicate Maximum Copayment amount for Prosthodontics, Other Oral/Maxillofacial Surgery, Other Services:	$0.00
Is authorization required?	Yes
Is a referral required for Comprehensive Dental Services?	No

17a Eye Exams

Service Category Description

Benefit Description

Question	Response
Does the plan provide Eye Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefit:	Routine Eye Exams
Select type of benefit for Routine Eye Exams:	Mandatory
Is this benefit unlimited for Routine Eye Exams?	No, indicate number

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17a Eye Exams Service Category Description Benefit Description	
Question	**Response**
Indicate number of exams for Routine Eye Exams:	1
Select the Routine Eye Exams periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Eye Exams:	$0.00
Indicate Maximum Copayment amount for Routine Eye Exams:	$0.00
Is there an enrollee Deductible?	No
Is authorization required?	No
Is a referral required for Eye Exams?	No

17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Eyewear as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Contact lenses; Eyeglasses (lenses and frames); Eyeglass lenses; Eyeglass frames
Select type of benefit for Contact lenses:	Mandatory
Is this benefit unlimited for Contact lenses?	Yes
Select type of benefit for Eyeglasses (lenses and frames):	Mandatory
Is this benefit unlimited for Eyeglasses (lenses and frames)?	Yes
Select type of benefit for Eyeglass lenses:	Mandatory
Is this benefit unlimited for Eyeglass lenses?	Yes
Select type of benefit for Eyeglass frames:	Mandatory
Is this benefit unlimited for Eyeglass frames?	Yes

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17b Eyewear Service Category Description Benefit Description	
Question	**Response**
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Do you offer a Combined Max Plan Benefit Coverage Amount for all Eyewear?	Yes
Indicate Combined Maximum Plan Benefit Coverage amount:	500.00
Select the Combined Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Deductible?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Is authorization required?	No
Is a referral required for Eyewear?	No
Notes:	Eyewear benefit maximum amount includes repair of eyewear. This benefit amount is combined with a hearing aid maximum amount. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Exams as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Routine Hearing Exams; Fitting/Evaluation for Hearing Aid
Select type of benefit for Routine Hearing Exams:	Mandatory
Is this benefit unlimited for Routine Hearing Exams?	No, indicate number
Indicate number for Routine Hearing Exams:	1
Select Routine Hearing Exams periodicity:	Every year
Select type of benefit for Fitting/Evaluation for Hearing Aid:	Mandatory

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18a Hearing Exams Service Category Description Benefit Description	
Question	**Response**
Is this benefit unlimited for Fitting/Evaluation for Hearing Aid?	No, indicate number
Indicate number for Fitting/Evaluation for Hearing Aid:	1
Select Fitting/Evaluation for Hearing Aid periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	No
Is there an enrollee Deductible?	No
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Indicate Minimum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Maximum Copayment amount for Medicare-covered Benefits:	$0.00
Indicate Minimum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Maximum Copayment amount for Routine Hearing Exams:	$0.00
Indicate Minimum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Indicate Maximum Copayment amount for Fitting/Evaluation for Hearing Aid:	$0.00
Is authorization required?	No
Is a referral required for Hearing Exams?	No

18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the plan provide Hearing Aids as a supplemental benefit under Part C?	Yes
Select enhanced benefits:	Hearing Aids (all types)
Select type of benefit for Hearing Aids (all types):	Mandatory
Is this benefit unlimited for Hearing Aids (all types)?	No, indicate number
Indicate quantity for Hearing Aids (all types):	2
Select Hearing Aids (all types) periodicity:	Every year
Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes

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18b Hearing Aids Service Category Description Benefit Description	
Question	**Response**
Does the Maximum Plan Benefit Coverage Amount apply per ear or for both ears combined?	Both ears combined
Select the Maximum Plan Benefit Coverage type:	Plan-specified amount per period
Indicate Maximum Plan Benefit Coverage amount:	500.00
Indicate Maximum Plan Benefit Coverage periodicity:	Every year
Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
Is there an enrollee Coinsurance?	No
Is there an enrollee Copayment?	No
Is there an enrollee Deductible?	No
Does your plan cover OTC hearing aids as part of your hearing aid benefit?	No
Is authorization required?	Yes
Is a referral required for Hearing Aids?	Yes
Notes:	Benefit and Maximum Plan Coverage Amount includes benefit for repair of devices. This benefit is combined with the eyewear maximum amount.

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

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

19a Reduced Cost Sharing for VBID/UF/SSBCI	
Question	**Response**
Does your plan include MA Uniformity Flexibility with reductions in cost or additional benefits?	No
Do you offer Special Supplemental Benefits for the Chronically Ill?	No

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

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

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19b Additional Benefits for VBID/UF/SSBCI	
Question	**Response**
Does your VBID/MA Uniformity Flexibility/SSBCI benefit offer additional Part C benefits?	No
How many packages do your Additional Benefits contain? (1-15)	1

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
19b	Additional Benefits for VBID/UF/SSBCI	Is this package applicable to VBID or MA Uniformity Flexibility or SSBCI?	VBID
		Targeting Methodology - Please choose one or both:	Socioeconomic Status
		Select LIS reduction level:	Dual-Eligible Status (for territories)
		Expected Number of Enrollees to be Targeted:	3085
		Expected Number of Enrollees to be engaged and receive Model benefits:	3085
		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

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Notes:	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.
19b - 13i	Additional Benefits for VBID/UF/SSBCI - Non-Primarily Health Related Benefits for the Chronically Ill	Select what type of benefit your Non-Primarily Health Related Benefits for the Chronically Ill includes:	Food and Produce; Pest Control; Transportation for Non-Medical Needs; Indoor Air Quality Equipment and Services; Social Needs Benefit; Complementary Therapies; Services Supporting Self-Direction; General Supports for Living
		Does the plan provide Food and Produce as a supplemental benefit under Part C?	Yes
		Select type of benefit for Food and Produce:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	150.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Food and Produce?	No
		Notes:	Maximum Plan Benefit Coverage amount on VBID Benefits Card carries forward to the next period if it is unused.
		Does the plan provide Pest Control as a supplemental benefit under Part C?	Yes
		Select type of benefit for Pest Control:	Mandatory

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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Contrato Número

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

Disease States:

Service Category Description

Benefit Description

PBP Section	Category	Question	Response
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Indoor Air Quality Equipment and Services?	No
		Notes:	Air Quality Equipment and Services - including air conditioners, air purifiers, and dehumidifiers and associated filters, supplies, and maintenance/repair services - are covered through the VBID Benefits Card.
		Does the plan provide Social Needs Benefit as a supplemental benefit under Part C?	Yes
		Select type of benefit for Social Needs Benefit:	Mandatory
		Is there a service-specific Maximum Plan Benefit Coverage amount?	Yes
		Indicate Maximum Plan Benefit Coverage amount:	0.00
		Select Maximum Plan Benefit Coverage periodicity:	Every month
		Is there a service-specific Maximum Enrollee Out-of-Pocket Cost?	No
		Is there an enrollee Coinsurance?	No
		Is there an enrollee Deductible?	No
		Is there an enrollee Copayment?	No
		Is authorization required?	No
		Is a referral required for Social Needs Benefit?	No
		Notes:	Social Needs are covered through the VBID Benefits Card and include access to community or plan sponsored events to address social needs, events that address isolation and improve emotional and/or cognitive function, social cognitive function - Club memberships, park passes, musical events, counseling. This includes passes to concerts, museums, community entertainment events, gardening, arts and crafts, in addition to companionship to support attendance to all aforementioned events/activities.

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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EMR

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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

Disease States:

Service Category Description

Benefit Description

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

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Bid Reports 2024

PBP Part D Benefits Report

MCS ADVANTAGE, INC.
H5577 - 055
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Del Sur (HMO D-SNP)
Plan Geographic Name:	Puerto Rico South 8
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Number of Tiers:	
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

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

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

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

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

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

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Contrato Número EMR

Bid Reports 2024

Plan Service Area Report

MCS ADVANTAGE, INC.
H5577 - 055
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Del Sur (HMO D-SNP)
Plan Geographic Name:	Puerto Rico South 8
Status:	Version 2 - Renewal - Successfully exported to desk review (05/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
Part C Plan Premium:	$0.00
Part D Plan Premium:	N/A
Continuation Area Available:	No
Visitor/Travel Benefit Available:	US - No
Formulary:	Yes, 00024446
Part D Benefit:	Yes, Defined Standard
Special Needs Plan:	Yes
Special Needs Plan Type:	Dual-Eligible
Dual-Eligible SNP:	Medicare non-zero dollar cost sharing plan
Under this D-SNP, has the state agreed to cover all Medicare premiums and cost sharing for enrollees in your D-SNP?	Yes
Standard Bid For Section B:	No
Standard Bid For Section C:	No
Standard Bid For Section D:	No

State	County	County Code	Employer-Only County?	Pending County?	Partial County?
Puerto Rico	Coamo	40210	No	No	No Zipcode(s): 00769
Puerto Rico	Guayanilla	40290	No	No	No Zipcode(s): 00656; 00785
Puerto Rico	Juana Diaz	40370	No	No	No Zipcode(s): 00795
Puerto Rico	Penuelas	40550	No	No	No Zipcode(s): 00624
Puerto Rico	Ponce	40560	No	No	No Zipcode(s): 00715; 00716; 00717; 00728; 00730; 00731; 00732; 00733; 00734; 00780
Puerto Rico	Salinas	40620	No	No	No Zipcode(s): 00704; 00751
Puerto Rico	Santa Isabel	40670	No	No	No Zipcode(s): 00757

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Puerto Rico	Villalba	40750	No	No	No Zipcode(s): 00766

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SEGUROS DE SALUD

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Contrato Número EMR

Bid Reports 2024

Plan Level Cost Shares and Limits Report

MCS ADVANTAGE, INC.
H5577 - 055
VBID: Yes - Part C
MA Uniformity Flexibility: No
Special Supplemental Benefits for the Chronically Ill: No
Part D Senior Savings Model: No

Region:	New York
Lead Marketing Region:	New York
Org. Marketing Name:	MCS Classicare
Plan Name:	MCS Classicare Platino Del Sur (HMO D-SNP)
Plan Geographic Name:	Puerto Rico South 8
Status:	Version 2 - Renewal - Successfully exported to desk review (06/06/23)
Plan Type:	HMO
Enrollee Type:	Part A and Part B
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

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

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

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

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

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

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Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	17b1: Contact Lenses; 17b2: Eyeglasses (lenses and frames); 17b3: Eyeglass lenses; 17b4: Eyeglass frames; 18b1: Hearing Aids (all types)
What is your combined supplemental benefits mode of delivery?	Other
Other Description:	Combined Eyewear and Hearing Allowance
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	Yes
Max Plan Benefit Amount:	500.00
Select Maximum Plan Benefit Coverage Amount Periodicity:	Every year
Do you offer Combined Supplemental Benefits with a shared visit/trip limit?	No
Combined Benefits Group 2 Name:	Combined Transportation
Select which non-Medicare covered benefits are included in your Combined Supplemental Benefit package:	10b1: Transportation Services - Plan Approved Health-related Location; 19b: Additional Benefits for VBID/UF/SSBCI
What is your combined supplemental benefits mode of delivery?	Other
Other Description:	Transportation provided by contracted vendors.
Is the enrollee limited to one or more of the combined supplemental benefits from the package which they must select in advance?	No
Do you offer Combined Supplemental Benefits with a shared maximum plan benefit amount?	No
Do you offer Combined Supplemental Benefits with a shared visit limit?	Yes
Indicate number of shared visits:	12
Select visit limit periodicity:	Every year

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Contrato Número EMR

WORKSHEET 6 - MA BID
SUMMARY

I. General Information

1. Contract Number:	H5577	5. Organization Name:	MCS ADVANTAGE, INC.	9. Enrollee Type:	A/B	13. Region Name:
2. Plan ID:	055	6. Plan Name:	MCS Classicare Platino Del Sur (HMO D-SNP)	10. MA Region:	N/A	
3. Segment ID:	000	7. Plan Type:	HMO	11. Act. Swap/Equiv Apply:	N	
4. Contract Year:	2024	8. MA-PD:	Y	12. SNP:	Y	14. SNP Type:

II. Other Information

A. Part B Information		B. Rebate Allocation for Part B Premium	
1. Maximum Pt B premium buydown amt., per CMS	$164.90	1. PMPM Rebate Allocation for Part B premium (maximum value=$164.90)	$150.00
		2. Part B Rebate Allocation, rounded to one decimal (see instructions)	$150.00

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