SUMMARY OF BENEFITS

MCS Classicare Platino Ideal
(HMO D-SNP)

MCS Classicare Platino Máximo
(HMO D-SNP)

Region 1 | Region 2 | Region 3

MCS Classicare Platino Progreso
(HMO D-SNP)

MCS Classicare Platino Superior
(HMO D-SNP)

MCS Classicare Platino Total
(HMO D-SNP)

MCS Classicare Platino 185
(HMO D-SNP)

2026

MCS Classicare
(HMO)

Plan de Salud
medicare
PLATINO
Administración de Seguros de Salud
Gobierno de Puerto Rico

SUMMARY OF BENEFITS

BENEFITS	MCS Classicare PLATINO IDEAL (HMO D-SNP)	MCS Classicare PLATINO PROGRESO (HMO D-SNP)	MCS Classicare PLATINO TOTAL (HMO D-SNP)	NEW! MCS Classicare PLATINO 185 (HMO D-SNP)
PREMIUMS AND BENEFITS				
Monthly Plan Premium	You pay $0	You pay $0	You pay $0	You pay $0
Part B monthly premium reduction	$121 monthly	$45 monthly	$0 monthly	$185 monthly
Deductible	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) The maximum amount you pay for copays, coinsurance and other costs for in-network medical services for the year.	$3,400 annually	$3,400 annually	$3,400 annually	$3,400 annually
HOSPITAL COVERAGE [1,2]				
Inpatient Hospital coverage	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Outpatient hospital services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Ambulatory Surgical Center Services (ASC)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
DOCTOR VISITS				
Primary Care Providers	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Specialists[2]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Preventive Care (e.g., flu vaccine, diabetic screenings) Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Emergency Care Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Urgently Needed Services Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
DIAGNOSTIC SERVICES/LABS/IMAGING [1,2]				
Diagnostic tests and procedures	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Lab services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diagnostic Radiology services (e.g. MRI, CT Scan)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
X-rays	You pay nothing	You pay nothing	You pay nothing	You pay nothing
HEARING SERVICES				
Medicare-covered hearing exam	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Routine hearing exam - one (1) annually	You pay nothing	You pay nothing	You pay nothing	Not Covered
Fitting-evaluation for hearing aids - one (1) annually	You pay nothing	You pay nothing	You pay nothing	Not Covered
Hearing Aids [1,2,4]	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 8-9	Up to $1,500 per ear annually	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 8-9	Not Covered

SUMMARY OF BENEFITS

BENEFITS	MCS Classicare PLATINO IDEAL (HMO D-SNP)	MCS Classicare PLATINO PROGRESO (HMO D-SNP)	MCS Classicare PLATINO TOTAL (HMO D-SNP)	NEW! MCS Classicare PLATINO 185 (HMO D-SNP)
DENTAL SERVICES				
Medicare-covered Dental Services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diagnostic and Preventive Dental Services covered by Medicaid - Oral Exam - Dental X-rays - Prophylaxis (Cleaning) - Flouride Treatment No maximum benefit coverage applies for diagnostic and preventive services.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Comprehensive dental services [1,4] - Restorative Services (including Crowns) - Prosthodontics (Fixed and Removable)	Up to $3,500 annually	Up to $4,500 annually	Up to $1,200 annually	Only services covered by Medicaid
VISION SERVICES				
Medicare-covered Eye Exam	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Routine Eye Exam - one (1) annually	You pay nothing	You pay nothing	You pay nothing	Not covered
Eyewear [4]	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 8-9	Up to $1,000 annually	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 8-9	Not covered. Refer to your evidence of coverage for services covered by Medicaid.
MENTAL HEALTH SERVICES				
Inpatient Hospital Psychiatric [3] Refer to the section Summary of Benefits Covered by the Puerto Rico Department of Health's Medicaid Program for information regarding unlimited days under our Platino plan. Our plan covers up to 190 days in a lifetime for inpatient mental therapy visit health care in a psychiatric hospital. The inpatient hospital care limit does not apply to psychiatric inpatient hospital services provided in a general hospital.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Outpatient Individual Therapy Visit [3] Outpatient Group Therapy Visit	You pay nothing	You pay nothing	You pay nothing	You pay nothing

SUMMARY OF BENEFITS

BENEFITS	MCS Classicare PLATINO IDEAL (HMO D-SNP)	MCS Classicare PLATINO PROGRESO (HMO D-SNP)	MCS Classicare PLATINO TOTAL (HMO D-SNP)	NEW! MCS Classicare PLATINO 185 (HMO D-SNP)
ADDITIONAL BENEFITS				
Skilled Nursing Facility [1,2] Our plan covers up to 100 days. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Physical Therapy [1] Occupational therapy, and speech therapy is covered [1].	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Ambulance Air Ambulance [1] Ground ambulance	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Transportation [4,6] A trip is considered one-way transportation to a plan approved health-related location.	For up to 32 one-way trips annually	For up to 45 one-way trips annually	For up to 30 one-way trips annually	For up to 12 one-way trips annually
MEDICARE PART B DRUGS				
Chemotherapy drugs and radiation [1]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Other Part B drugs [1]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Insulin drugs	You pay nothing	You pay nothing	You pay nothing	You pay nothing
MEDICAL EQUIPMENT/ SUPPLIES [1]				
Durable medical equipment (DME)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Prosthetic devices	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diabetic supplies	You pay nothing	You pay nothing	You pay nothing	You pay nothing
WELLNESS PROGRAMS				
Fitness Benefit through MCS Wellness Programs	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Nursing Hotline (*MCS Medilínea*)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
WELLNESS BENEFITS				
Medicare Covered Podiatry Services [2]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Foot Reflexology Must be ordered by a physician or medical professional.	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	Not covered
Remote Access Technologies (Telemedicine) Remote Access Technologies services allow you to receive medical attention from anywhere within Puerto Rico 365 days a year. You have access to health consultations for a minor illness with general practitioner or licensed emergency physician. If the doctor determines that your condition cannot be treated through this platform, you will be referred to an emergency room, an urgency center, or your primary doctor. Telemedicine visits can be done by cell phone, computer, or tablet. Does not apply for services outside the contracted platform. See your Evidence of Coverage for more details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Additional acupuncture services	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	Not covered

SUMMARY OF BENEFITS

BENEFITS	MCS Classicare PLATINO IDEAL (HMO D-SNP)	MCS Classicare PLATINO PROGRESO (HMO D-SNP)	MCS Classicare PLATINO TOTAL (HMO D-SNP)	NEW! MCS Classicare PLATINO 185 (HMO D-SNP)
SUPPLEMENTAL BENEFITS [4,6,7]				
 *Te Paga* Card	$960 annually ($80 monthly) [5]	$1,032 annually ($86 monthly)	$3,000 annually ($250 monthly)	Not covered
Healthy food box	Not Covered	Not Covered	Not Covered	1 box quarterly
Home assistance Services include hairstyling, yard clean-up, plumbing, locksmith, electricity, pest control, technology assistance, and preventive home cleaning/disinfection. Only simple repairs and basic services apply, according to the evaluation performed by the service supplier. For hairstyling (wash, cut, dry) you must visit participating establishments to receive these services. Contact the Home Assistance supplier for more details.	Twelve (12) visits annually (maximum 3 quarterly)	Sixteen (16) visits annually (maximum 4 quarterly)	Twelve (12) visits annually (maximum 3 quarterly)	Twelve (12) visits annually (maximum 3 quarterly)
Transportation for non-health related needs Trips used for non-medical needs count against the maximum limit of your health-related transportation benefit.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
OTHER SUPPLEMENTAL BENEFITS				
Combined Benefits for Eyewear and Hearing Services [1,2,4,9]	Up to $500 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined.	N/A	Up to $500 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined.	Not covered
In-Home Foot Care Benefit [5] One (1) visit per quarter for specialized foot care will be provided in the home by trained foot professional approved by the plan.	You pay nothing	Not Covered	Not Covered	Not covered

SUMMARY OF BENEFITS

BENEFITS	Access to the provider network throughout Puerto Rico [8]			
	MCS Classicare Platino Máximo (HMO D-SNP) Region 1	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 2	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 3	NEW! **MCS Classicare PLATINO SUPERIOR** (HMO D-SNP)
PREMIUMS AND BENEFITS				
Monthly Plan Premium	You pay $0	You pay $0	You pay $0	You pay $0
Part B monthly premium reduction	$80 monthly	$80 monthly	$80 monthly	$125 monthly
Deductible	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible	This plan does not have a deductible
Maximum Out-of-Pocket Responsibility (does not include prescription drugs) The maximum amount you pay for copays, coinsurance and other costs for in-network medical services for the year.	$3,400 annually	$3,400 annually	$3,400 annually	$3,400 annually
HOSPITAL COVERAGE [1,2]				
Inpatient Hospital coverage	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Outpatient hospital services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Ambulatory Surgical Center Services (ASC)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
DOCTOR VISITS				
Primary Care Providers	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Specialists[2]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Preventive Care (e.g., flu vaccine, diabetic screenings) Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Emergency Care Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Urgently Needed Services Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
DIAGNOSTIC SERVICES/LABS/IMAGING [1,2]				
Diagnostic tests and procedures	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Lab services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diagnostic Radiology services (e.g. MRI, CT Scan)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
X-rays	You pay nothing	You pay nothing	You pay nothing	You pay nothing

SUMMARY OF BENEFITS

BENEFITS	Access to the provider network throughout Puerto Rico [8]			
	MCS Classicare Platino Máximo (HMO D-SNP) Region 1	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 2	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 3	NEW! **MCS Classicare PLATINO SUPERIOR** (HMO D-SNP)
HEARING SERVICES				
Medicare-covered hearing exam	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Routine hearing exam - one (1) annually	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Fitting-evaluation for hearing aids - one (1) annually	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Hearing aids [1,2,4]	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17
DENTAL SERVICES				
Medicare-covered Dental Services	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diagnostic and Preventive Dental Services covered by Medicaid - Oral Exam - Dental X-rays - Prophylaxis (Cleaning) - Flouride Treatment No maximum benefit coverage applies for diagnostic and preventive services.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Comprehensive dental services [1,4] - Restorative Services (including Crowns) - Prosthodontics (Fixed and Removable)	Up to $1,200 annually	Up to $1,200 annually	Up to $1,200 annually	Up to $4,000 annually
VISION SERVICES				
Medicare-covered Eye Exam	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Routine Eye Exam - one (1) annually	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Eyewear [4]	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17	See "Combined benefit for Eyewear and Hearing Aids for both ears combined." on page 16-17
MENTAL HEALTH SERVICES				
Inpatient Hospital Psychiatric [3] Refer to the section Summary of Benefits Covered by the Puerto Rico Department of Health's Medicaid Program for information regarding unlimited days under our Platino plan. Our plan covers up to 190 days in a lifetime for inpatient mental therapy visit health care in a psychiatric hospital. The inpatient hospital care limit does not apply to psychiatric inpatient hospital services provided in a general hospital.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Outpatient Individual Therapy Visit [3] Outpatient Group Therapy Visit	You pay nothing	You pay nothing	You pay nothing	You pay nothing

SUMMARY OF BENEFITS

BENEFITS	Access to the provider network throughout Puerto Rico [8]			
	MCS Classicare Platino Máximo (HMO D-SNP) Region 1	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 2	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 3	NEW! **MCS Classicare PLATINO SUPERIOR** (HMO D-SNP)
ADDITIONAL BENEFITS				
Skilled Nursing Facility [1,2] Our plan covers up to 100 days. Contact the plan for details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Physical Therapy [1] Occupational therapy, and speech therapy is covered [1].	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Ambulance Air Ambulance [1] Ground ambulance	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Transportation [4,6] A trip is considered one-way transportation to a plan approved health-related location.	For up to 18 one-way trips annually	For up to 18 one-way trips annually	For up to 18 one-way trips annually	For up to 44 one-way trips annually
MEDICARE PART B DRUGS				
Chemotherapy drugs and radiation [1]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Other Part B drugs [1]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Insulin drugs	You pay nothing	You pay nothing	You pay nothing	You pay nothing
MEDICAL EQUIPMENT/ SUPPLIES [1]				
Durable medical equipment (DME)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Prosthetic devices	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Diabetic supplies	You pay nothing	You pay nothing	You pay nothing	You pay nothing
WELLNESS PROGRAMS				
Fitness Benefit through MCS Wellness Programs	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Nursing Hotline (*MCS Medilínea*)	You pay nothing	You pay nothing	You pay nothing	You pay nothing
WELLNESS BENEFITS				
Medicare Covered Podiatry Services [2]	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Foot Reflexology Must be ordered by a physician or medical professional	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually

SUMMARY OF BENEFITS

BENEFITS	Access to the provider network throughout Puerto Rico [8]			
	MCS Classicare Platino Máximo (HMO D-SNP) Region 1	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 2	**MCS Classicare Platino Máximo** (HMO D-SNP) Region 3	NEW! **MCS Classicare PLATINO SUPERIOR** (HMO D-SNP)
Remote Access Technologies (Telemedicine) Remote Access Technologies services allow you to receive medical attention from anywhere within Puerto Rico 365 days a year. You have access to health consultations for a minor illness with general practitioner or licensed emergency physician. If the doctor determines that your condition cannot be treated through this platform, you will be referred to an emergency room, an urgency center, or your primary doctor. Telemedicine visits can be done by cell phone, computer, or tablet. Does not apply for services outside the contracted platform. See your Evidence of Coverage for more details.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
Additional acupuncture services	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually	You pay nothing Six (6) visits annually
SUPPLEMENTAL BENEFITS [4, 6, 7]				
 *Te Paga* Card	$2,400 annually ($200 monthly)	$1,740 annually ($145 monthly)	$1,260 annually ($105 monthly)	$1,080 annually ($90 monthly) [5]
Home assistance Services include hairstyling, yard clean-up, plumbing, locksmith, electricity, pest control, technology assistance, and preventive home cleaning/disinfection. Only simple repairs and basic services apply, according to the evaluation performed by the service supplier. For hairstyling (wash, cut, dry) you must visit participating establishments to receive these services. Contact the Home Assistance supplier for more details.	Twelve (12) visits annually (maximum 3 quarterly)	Twelve (12) visits annually (maximum 3 quarterly)	Twelve (12) visits annually (maximum 3 quarterly)	Twelve (16) visits annually (maximum 4 quarterly)
Transportation for non-health related needs Trips used for non-medical needs count against the maximum limit of your health-related transportation benefit.	You pay nothing	You pay nothing	You pay nothing	You pay nothing
OTHER SUPPLEMENTAL BENEFITS				
Combined Benefits for Eyewear and Hearing Services [1,2,4,9]	Up to $500 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined	Up to $500 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined	Up to $500 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined	Up to $600 annually Combined Benefit for Eyewear and Hearing Aids for both ears combined

SUMMARY OF BENEFITS

PRESCRIPTION DRUGS

For more information about the phases of the benefit, please call us or access your Evidence of Coverage online.

STAGE 1: YEARLY DEDUCTIBLE STAGE

Because there is no deductible for the plan, this payment stage does not apply to you.

STAGE 2: INITIAL COVERAGE STAGE

You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100. You then move on to the Catastrophic Coverage Stage.

STANDARD RETAIL COST SHARING (30-DAY SUPPLY)

Covered drugs	$0 copay

STANDARD RETAIL COST SHARING (90-DAY SUPPLY)

Covered drugs	$0 copay

MAIL-ORDER COST SHARING (UP TO A 90-DAY SUPPLY)

Covered drugs	$0 copay

STAGE 3: CATASTROPHIC COVERAGE STAGE

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $2,100 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered drugs.

Summary of Benefits Covered by the Puerto Rico Department of Health's Medicaid Program

The following services are available only to Special Needs Plans beneficiaries who are eligible for the Puerto Rico Department of Health's Medicaid Program health services. The benefits described below are covered by the Puerto Rico Department of Health's Medicaid Program. The benefits described in the Medical and Hospital Benefits section of the Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what the Government Health Plan (GHP) covers and what our plan covers.

PRODUCTS

MCS Classicare Platino Ideal (HMO D-SNP)

MCS Classicare Platino Máximo (HMO D-SNP)
Región 1 | Región 2 | Región 3

MCS Classicare Platino Progreso (HMO D-SNP)

MCS Classicare Platino Superior (HMO D-SNP)

MCS Classicare Platino Total (HMO D-SNP)

MCS Classicare Platino 185 (HMO D-SNP)

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Monthly Premium	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 per month**
Inpatient Hospital Services	**Admissions** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 **Nursery** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year. Coverage includes: • Isolation room for medical reasons. • Specialized diagnostic/treatment such as electrocardiograms, electroencephalograms, arterial gases, and other specialized diagnostic and/or treatment testing that are available in the hospital facilities and which are required to be performed while the patient is hospitalized. • Short Term Rehabilitation Services: To hospitalize patients, including physical, occupational, and speech therapy.	**Admissions** **$0 copay** **Nursery** **$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Inpatient Hospital Services (continued)	Blood: Blood, plasma and their derivatives without limitations, to include irradiated and antilogous blood; Monoclonal Factor IX per authorization of a certified hematologist; Antihemophilic Factor with intermediate purity concentration (Factor VIII) A; Antihemophilic Monoclonal Type Factor per authorization of a certified hematologist and Prothrombin Activated Complex (Autoflex and Feiba) per authorization of a certified hematologist.	
Inpatient Hospital for Mental Health Diseases	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year.	**$0 copay**
Inpatient Substance Use Disorder	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Coverage begins on first day of Medicare and Platino Wrap around apply on any non-covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year.	**$0 copay**
Outpatient Substance Use Disorder	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Coverage begins on the first day of Medicare, and Platino Wrap Around apply on any non- covered benefit under the MAO supplementary benefit coverage and included as covered services on Medicaid state plan. Access to a semiprivate room (bed available twenty-four (24) hours a day, every Calendar Day of the year.	**$0 copay**
Outpatient Mental Healthcare and Professional Services	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 All mental health related OPD services and twenty-four (24) hours a day, seven (7) days a week emergency and crisis intervention non- covered by Medicare or the MAO supplementary benefits but included in the State Plan.	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Laboratory and High-Tech Laboratories	Coverage Code 100: $0 Coverage Code 120: $0 Coverage Code 110: $0 Coverage Code 130: $0 Laboratory testing and necessary procedures related to generating a Health Certificate non-covered by Medicare or the Medicare Advantage Organization (MAO) supplementary benefits but included in the State Plan. Heath Certificates are covered under the GHP, provided that cost sharing and/or deductibles applicable for necessary procedures and laboratory testing related to generating a Health Certificate will be the Enrollee's responsibility. Such certificates shall include: •Venereal Disease Research Laboratory("VDRL") tests. • Tuberculosis ("TB") tests; and • Hepatitis C virus: Anti HCV and or HCV-RNA as required. • Hepatitis B virus: HBsAg; HBcAb IgM and or IbG If needed. Hepatitis A virus: HAV IgM; HAV RNA, as required. I • Any Certification for GHP Enrollees related to eligibility for the Medicaid Program (provided at no charge).	**$0 copay**
Family Planning	Coverage Code 100: $0 Coverage Code 120: $0 Coverage Code 110: $0 Coverage Code 130: $0 Family planning services non- covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Puerto Rico Medicaid benefits provide reproductive health and family planning counseling. Such services shall be provided voluntarily and confidentially, including circumstances where the beneficiary is under age eighteen (18). Family planning services will include, at a minimum, the following: • Education and counseling • Pregnancy testing • Infertility assessment • Sterilization services in accordance with 42 CFR 441.200 subpart F; • Laboratory services • Cost and insertion/removal of non-oral products, such as long acting reversible contraceptives (LARC) • At least one of every class and category of FDA- approved contraceptive • At least one of every class and category of FDA- approved contraceptive method • And other FDA approved contraceptive medications or methods when it is medically necessary and approved through a prior authorization or through an exception process and the prescribing provider can demonstrate at least one of the following situations: o Contra-indication with drugs that the enrollee is already taking, and no other methods covered/available that can be used by the enrollee. o History of adverse reaction by the enrollee to the contraceptive methods covered. o History of adverse reaction by the enrollee to the contraceptive medications that are covered.	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Tobacco Cessation	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Tobacco cessation services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Smoking cessation drugs are covered for individuals under age 21 and for pregnant women when medically necessary and prescribed by a physician. In these cases, the plan covers prescription and non-prescription aids as indicated by a physician.	**$0 copay**
Maternity Services	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Maternity services non-covered by Medicare and/or the Medicare Advantage Organization (MAO) supplementary benefits but included in the State Plan. Abortions when the pregnancy is a result of rape or incest, as certified by a physician. Severe and long-lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.	**$0 copay**
Medical and Surgical	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Medical and surgical services non- covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Voluntary sterilization of men and women of legal age and sound mind, provided that they have been previously informed about the medical procedure's implications, and that there is evidence of enrollee's written consent by completing the Sterilization Consent Form.	**$0 copay**
Vision Services	Coverage Code 100: $0 Coverage Code 110: $1 Coverage Code 120: $1.50 Coverage Code 130: $2 Vision services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Eyeglasses or lenses for beneficiaries between the ages of 0-21 years when medically necessary will be cover, the benefit of eyeglasses and lens consist of a single or multifocal lens and a standard frame eyeglass every 24 months.	**$0 copay** This benefit is covered every year with MCS Classicare Platino coverage. Provider and/or member must verify remaining combined maximum plan benefit coverage amount available.

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Vision Services (continued)	All types of lenses have to be preauthorized except intraocular lenses. Repair or replacement of eyeglasses within 24 months when this is medically necessary and approved by the pre-authorization will be covered.	
Dental Services, Preventive and Restorative **Preventive (child)** **Preventive (adult)** **Restorative**	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Dental services non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. The following are the benefits included in the GHP: • All preventative and corrective services for children under age twenty- one (21) • Pediatric pulp therapy (pulpotomy) for children under age twenty-one (21); • Stainless steel crowns for use in primary teeth following a pediatric pulpotomy; • Preventive dental services for adults. • Restorative dental services for adults. • One (1) comprehensive oral exam per year. • One (1) periodical exam every six months. • One (1) defined problem- limited oral exam • One (1) full series of intra oral radiographies, including bite, every three (3) years. • One (1) initial periapical intra-oral radiography. • Up to five (5) additional periapical/intra-oral radiographies per year. • One (1) single-film bite radiography per year. • One (1) two-film bite radiography per year. • One (1) panoramic radiography every three (3) years. • One (1) adult cleanses every six (6) months. • One (1) child cleanses every six (6) months. • One (1) topical fluoride application every six (6) months for enrollees under nineteen (19) years old. • Fissure sealants for life for enrollees up to fourteen (14) years old, including decidual molars up to eight (8) years old when medically necessary because of cavity tendencies. • Amalgam restoration; • Resin restorations; • Root canal; • Palliative treatment; and • Oral surgery • Sedation and anesthesia services for beneficiaries with physical or mental handicaps in compliance with local laws.	**$0 copay** **$0 copay** **$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Dental Services, Preventive and Restorative (continued)	• Periodontal Scaling and root planing up to 4 quadrants per beneficiary. • Interim removable partial dentures (upper and lower). • Hospital visits. • All limitations may be exceeded based on medical necessity and approved thorough prior preauthorization or exemption process.	
Hearing Exams	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Hearing related services non- covered by Medicare and/or the MAO supplementary benefits but included in the State Plan.	**$0 copay**
Preventive Services **All immunizations required for post bone marrow transplant patients.**	Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 **Immunization services non-covered by:** 1. Medicare Part B 2. MAO Part D drug formulary 3. MAO supplementary plan benefits 4. Not covered by the Puerto Rico Department of Health Immunization Program but included in the Puerto Rico Medicaid State Plan.	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Preventive Services (continued)	**Vaccines for children from 0-20 years of age (inclusive)** • Hepatitis A • Hepatitis B • Rotavirus (RV) • DTaP (Diphtheria toxoids and acellular pertussis vaccine) • Hib (Hib conjugate vaccine) • PCV 15, PCV13, and PPSV23 (Anti-Pneumococcal vaccines): Child and Adolescent Immunization Schedule Changes for 2023. CDC. • Polio (IPV) • Vaccines against influenza (attenuated virus LAIV or IIV) • MMR • Varicella (VAR) • Anti-Meningococcal vaccines - MenACWY-D [Menactra], MenACWY-CRM (Menveo). The MenACWY note was updated to include language stating the <u>newly licensed Menveo® one-vial (all liquid) formulation should not be administered before age 10 years</u>. MenB (meningococcal serogroup B MenB-4C [Bexserol] and MenB-FHbp [Trumenba] • Tdap • Human Papillomavirus (HPV) • Dengvaxia (Indicated for the prevention of dengue disease caused by dengue virus serotypes 1, 2, 3 and 4 is approved for use in individuals 9 through 16 years of age with laboratory-confirmed previous dengue infection and living in endemic areas. The Dengue note was **<u>revised</u>** to clarify that the dengue vaccine is recommended for seropositive children living in endemic areas, **<u>not for children traveling to or visiting endemic dengue areas</u>**. **COVID 19**: Added new abbreviations for the COVID-19 vaccine products. These abbreviations contain information on the vaccine's valency (i.e., monovalent versus bivalent, indicated by "**1v**" and "**2v**," respectively) and vaccine platform (**mRNA** versus acellular protein subunit, or "**aPS**") **Vaccines for adults from 21 years of age** • Haemophilus influenzae type b vaccine – Hib • Hepatitis A vaccine – HepA • Hepatitis A and hepatitis B vaccine - HepA-HepB • Hepatitis B vaccine – HepB • Human papilloma virus vaccine – HPV • Influenza vaccine (inactivated) - IIV4	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Preventive Services (continued)	• Influenza vaccine (live, attenuated) - LAIV4 • Influenza vaccine (recombinant) - RIV4 • Measles, mumps, and rubella vaccine – MMR • Meningococcal serogroups A, C, W, Y vaccine o MenACWY-D o MenACWY-CRM o MenACWY-TT • Meningococcal serogroup B vaccine o MenB-4C o MenB-FHbp **Monkey Pox. Mpox (some adults in age group should get the vaccine)** • Pneumococcal 15-valent conjugate vaccine - PCV15 • Pneumococcal 20-valent conjugate vaccine - PCV20 • Pneumococcal 23-valent polysaccharide vaccine - PPSV23 **Respiratory Syncytial Virus- RSV (19-49 if pregnant during RSC season.) (60 years and older)** • Tetanus and diphtheria toxoids – Td • Tetanus and diphtheria toxoids and acellular pertussis vaccine – Tdap • Varicella vaccine – VAR • Zoster vaccine, recombinant - RZV **Post-transplanted bone marrow patients of any age will be covered for all required vaccinations.** **COVID 19 Vaccine -** not included in the Medicaid Wrap Around but are provided by the Department of Health (DOH). MAO must follow the instructions provided by CMS.	
Physical, Respiratory, Occupational and Speech Therapy Covered without limits under Medicare Part B (Medical Insurance). Do not apply within Wrap-Around.	• Physical Therapy Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Occupational Therapy Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Respiratory Therapy Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Speech Therapy Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Emergency Room (ER) Services	• Emergency Room (ER) Visit Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Non-Emergency Services Provided in a Hospital Emergency Room, (per visit) Coverage Code 100: $0 Coverage Code 110: $4 Coverage Code 120: $5 Coverage Code 130: $8	**$0 copay**
	• Non-Emergency Services Provided in a Freestanding Emergency Room, (per visit) Coverage Code 100: $0 Coverage Code 110: $2 Coverage Code 120: $3 Coverage Code 130: $4	**$0 copay**
	• Trauma Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
Ambulatory Visits	• Primary Care Physician (PCP) Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Specialist Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Subspecialist Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Prenatal services Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Special Coverage	Coverage Code 100: $0 Coverage Code 110: $1 Coverage Code 120: $1.50 Coverage Code 130: $2 Special Coverage includes services related to: • HIV/AIDS • Tuberculosis • Leprosy • Systemic Lupus Erythematosus (SLE) • Cystic Fibrosis • Cancer • Hemophilia • ESRD - Levels 3, 4 and 5 • Multiple Sclerosis & Amyotrophic Lateral Sclerosis (ALS) • Scleroderma • Pulmonary Hypertension • Aplastic Anemia • Rheumatoid Arthritis • Autism • Skin cancer: carcinoma IN SITU • Skin cancer: Invasive Melanoma or squamous cells with evidence of metastasis • Adults with Phenylketonuria • Chronic Hepatitis C • Congestive Heart Failure (CHF), Class III and IV, New York Heart Association (NYHA) in a potential candidate for heart transplant • Primary Ciliary Diskinecia (PCD) / Inmotile Ciliary Syndrome / Syndrome de Kartagener • Inflammatory Bowel Disease (IBD): Crohn's disease; Ulcerative Colitis and Microscopic Colitis • Post-Transplant	**$0 copay** **The homebound is also established under the MCS Classicare Special Conditions Registry. Contact the plan for details.**
Other Services	• High-Tech Laboratories** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Clinical Laboratories** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• X-Rays** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Other Services (continued)	• Special Diagnostic Tests** Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 **Applies only to diagnostic tests. Copays do not apply to the test required as part of a preventive service.	**$0 copay**
	• Healthy Child Care Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
	• Physical Exam Coverage Code 100: $0 Coverage Code 110: $1 Coverage Code 120: $1.50 Coverage Code 130: $2	**$0 copay**
	• Ambulatory Surgery Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**$0 copay**
Prescription Drugs	Prescription Drugs Preferred (Children 0-20 years of age) Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 Preferred (Adult) **** Coverage Code 100: $0 Coverage Code 110: $1 Coverage Code 120: $2 Coverage Code 130: $3 Non-Preferred (Children 0-20 years of age) Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0	**Prescription Drugs** **$0 for all covered drugs.** **$0 for outpatient substance abuse drugs**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Prescription Drugs (continued)	Prescription Drugs Non-Preferred (Adult) **** Coverage Code 100: $0 Coverage Code 110: $3 Coverage Code 120: $4 Coverage Code 130: $6 Outpatient Substance Abuse Coverage Code 100: $0 Coverage Code 110: $0 Coverage Code 120: $0 Coverage Code 130: $0 *** Copays apply to each drug included in the same prescription pad. **** Copays for children 0-20 years of age are not applicable for Medicaid, Commonwealth* medically indigent eligible, and for children 0-20 enrolled in the CHIP* Program in group ages 0-20. Prescription drugs non-covered by Medicare and/or the MAO supplementary benefits but included in the State Plan. Any cost sharing not included on the MAO benefit design as approved by CMS, including deductible, co insurances or coverage gaps exceeding the State plan. The drug needs to be in the GHP formulary and needs to be subject to the applicable edits as established in the GHP Formulary of Medications in Coverage (FMC). It also needs to comply with the followings: • All MAOs pharmacy benefit will provide full year drug coverage with their CMS approved Part D Drugs Formulary, and subject to established Platino copayments as the only out of pocket contribution. • Drugs not included in the MAOs Part D Drugs Formulary should undergo CMS required exception process for possible approval of non- covered drugs. If exception process denial is sustained by the MAOs, including the appeal process, but if the drug is covered by the GHP Formulary, the drug will be covered under Wrap Around. The prescriber physician needs to exhaust available MAO Formulary on the needed drug category. • Wrap Around drugs to be considered, need to be part of the GHP Formulary. All MAO's Part D Drugs Formularies should have the same therapeutic classes as GHP Formulary.	**Prescription Drugs** **$0 for all covered drugs.** **$0 for outpatient substance abuse drugs** **Outpatient Prescription Drugs** **Cost-sharing may change at out -of-network pharmacies. For more information please call us or see Chapter 6, Section 5.2 of the Evidence of Coverage.**

Benefit Category	Department of Health's Medicaid Program Goverment Health Plan (GHP)	Coverage
Prescription Drugs (continued)	1. The following Medicaid/CHIP Beneficiaries* are exempt of copays independent of their coverage code: • Children from 0 to less than 21 years of age (0-20 years, inclusive) • Pregnant women (during pregnancy and the 60-day post-partum period); • American Indians and Alaskan Natives (AI/AN) • Institutionalized Individuals; and • Individuals receiving hospice care. 2. Medicaid/CHIP* Beneficiaries are exempt of copays when receiving any of the following services: • Emergency services, including ambulatory, hospital, and post-stabilization services as defined in federal regulations 1932(b)(2) of the Act and 42 CFR 438.114(a); • Family planning services and supplies; • Preventative services provided to children less than 18 years of age (0- 17 years, inclusive) • Pregnancy-related services and counseling, and drugs for cessation of tobacco use; • Provider-preventable services as defined in 42 CFR 447.26(b); 3. No copay for services provided by a Preferred Network Participating Provider. Pharmacies and dentists are not part of the Preferred Provider Network. 4. Non-emergency visit to a hospital emergency room may be waived by calling the MCO call center and receiving a code to waiver co-pay.	

NOTE: Authorization and referrals requirements mentioned in previous sections are also applicable for the Benefits Covered by the Puerto Rico Department of Health's Medicaid Program section. Referrals do not apply to conditions under Special Coverage once you are registered.

This is a summary of drug and health services covered by MCS Classicare.

January 1 2026 – December 31 2026

MCS Classicare is a product offered by MCS Advantage, Inc. MCS Classicare is an HMO plan with a Medicare contract and a contract with the Puerto Rico Medicaid Program. Enrollment in MCS Classicare depends on contract renewal. Based on a Model of Care review, MCS Classicare has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2026.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services that we cover, please visit our website at **www.mcsclassicare.com** to view your *2026 Evidence of Coverage*.

To join an **MCS Classicare (HMO D-SNP)** plan you must have Medicare Part A, **be enrolled in Medicare Part B and the Government Health Plan (GHP)** and live in our service area. You are also eligible for membership in our plan as long as you are a United States citizen, are lawfully present in the United States or were a member of a different plan that was terminated.

For **MCS Classicare Platino Ideal (HMO D-SNP)**, **MCS Classicare Platino Progreso (HMO D-SNP)**, **MCS Classicare Platino 185 (HMO D-SNP)** and **MCS Classicare Platino Total (HMO D-SNP)**, our service area includes the 78 municipalities in Puerto Rico.

For **MCS Classicare Platino Máximo (HMO D-SNP) Region 1**, the service area for MCS Classicare Platino Máximo (HMO D-SNP) Region 1 is available to beneficiaries residing in any of the following 13 eligible municipalities:

Aguada, Aguadilla, Añasco, Arecibo, Camuy, Hatillo, Isabela, Mayagüez, Moca, Quebradillas, Rincón, San Sebastián and Utuado.

The service area for **MCS Classicare Platino Máximo (HMO D-SNP) Region 2** is available to beneficiaries residing in any of the following 21 eligible municipalities:

Adjuntas, Barceloneta, Cabo Rojo, Ciales, Corozal, Florida, Guánica, Hormigueros, Jayuya, Lajas, Lares, Las Marías, Manatí, Maricao, Morovis, Orocovis, Sabana Grande, San Germán, Vega Alta, Vega Baja y Yauco.

The service area for **MCS Classicare Platino Máximo (HMO D-SNP) Region 3** is available to beneficiaries residing in any of the following 44 eligible municipalities:

Aguas Buenas, Aibonito, Arroyo, Barranquitas, Bayamón, Caguas, Canóvanas, Carolina, Cataño, Cayey, Ceiba, Cidra, Coamo, Comerío, Culebra, Dorado, Fajardo, Guayama, Guayanilla, Guaynabo, Gurabo, Humacao, Juana Díaz, Juncos, Las Piedras, Loiza, Luquillo, Maunabo, Naguabo, Naranjito, Patillas, Peñuelas, Ponce, Río Grande, Salinas, San Juan, San Lorenzo, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Vieques, Villalba and Yabucoa.

The service area for **MCS Classicare Platino Superior (HMO D-SNP)** is available to beneficiaries residing in any of the following 37 eligible municipalities:

Aguada, Aguadilla, Añasco, Arroyo, Camuy, Canóvanas, Carolina, Cataño, Corozal, Dorado, Fajardo, Florida, Guayama, Guaynabo, Gurabo, Humacao, Isabela, Juncos, Lajas, Las Piedras, Manatí, Moca, Patillas, Peñuelas, Ponce, Rincón, Río Grande, San Juan, San Lorenzo, Toa Alta, Toa Baja, Trujillo Alto, Vega Alta, Vega Baja, Vieques, Villalba and Yauco.

MCS Classicare (HMO D-SNP) has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan may not pay for these services.

Getting Help from Medicare

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at **http://www.medicare.gov** or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Plan Documents in Other Formats and Languages

This information is available in different formats including large print, braille, and audio CD. This document is also available for free in Spanish. Please call our Call Center if you need plan information in another format or language.

Plan Phone Numbers and Website

For more information, please call us at the phone numbers below or visit us at **www.mcsclassicare.com**

If you are a member of this plan, call toll free 1-866-627-8183. TTY users should call 1-866-627-8182.

If you are not a member of this plan, call (Metro Area) 787-296-9003 and (Toll Free) 1-866-591-4002. TTY users should call 1-866-627-8182.

Hours of Operation

From October 1 to March 31, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m.

From April 1 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 4:30 p.m.

After these business hours, for general information on your benefits you may leave us a voice message. We will return your call on our next business day.

Evidence of Coverage

You can see your Evidence of Coverage at our website at **www.mcsclassicare.com**

Plan Directories

You can see our plan's **providers and pharmacies directory** at our website at **www.mcsclassicare.com**

Drug Coverage

We cover Part D drugs. In addition, we cover Part B drugs such as chemotherapy and some drugs administered by your provider.

You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website at **www.mcsclassicare.com**

MEDICARE PLATINO BENEFICIARY

Let's keep going with MCS Classicare (HMO)

MCS Classicare Te Paga card [4, 6, 7, 8]

MCS Classicare Platino Total (HMO D-SNP)	MCS Classicare Platino Progreso (HMO D-SNP)	MCS Classicare Platino Ideal [5] (HMO D-SNP)
$3,000 annual ($250 monthly)	$1,032 annual ($86 monthly)	$960 annual ($80 monthly)

Regional

MCS Classicare Platino Máximo (HMO D-SNP) Region 1	MCS Classicare Platino Máximo (HMO D-SNP) Region 2	MCS Classicare Platino Máximo (HMO D-SNP) Region 3	MCS Classicare Platino Superior [5] (HMO D-SNP)
$2,400 annual ($200 monthly)	$1,740 annual ($145 monthly)	$1,260 annual ($105 monthly)	$1,080 annual ($90 monthly)

Part B monthly premium reduction

MCS Classicare Platino 185 (HMO D-SNP)	MCS Classicare Platino Ideal (HMO D-SNP)	Regional (All regions)	
		MCS Classicare Platino Superior (HMO D-SNP)	MCS Classicare Platino Máximo (HMO D-SNP)
$2,220 annual ($185 monthly)	$1,452 annual ($121 monthly)	$1,500 annual ($125 monthly)	$960 annual ($80 monthly)

The plan that gives you complete health with benefits such as:

Comprehensive dental [1,4]

$4,500 annual

MCS Classicare Platino Progreso (HMO D-SNP)

Eyewear [4]

$1,000 annual

MCS Classicare Platino Progreso (HMO D-SNP)

Healthy food box [4,5,6]

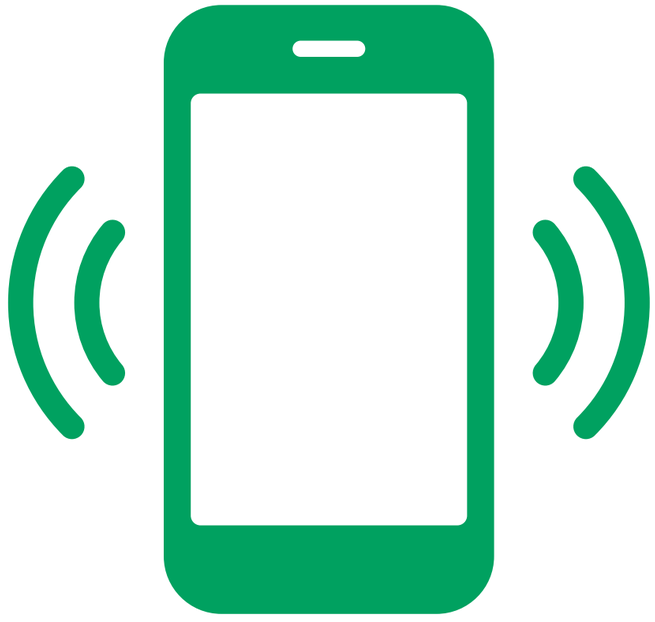
1 Box quarterly

MCS Classicare Platino 185 (HMO D-SNP)

Transportation [4, 6, 10]

Up to **45** one-way trips annually

MCS Classicare Platino Progreso (HMO D-SNP)



DID YOU KNOW...

As an active member of the plan, you have the option not to receive calls to discuss or talk about Medicare Advantage and Part D plans, as established by the Centers for Medicare and Medicaid Services (CMS), other Medicare plans (not the current plan) or other types of insurance or lines of business, for example, home insurance, among others. This does not include calls that are strictly necessary to receive your health plan benefits.

If you do not want to receive these types of calls, please contact the MCS Classicare Call Center at 787-620-2530 (metro area) or 1-866-627-8183 (toll free). TTY (Hearing impaired) may call 1-866-627-8182. Our service hours are Monday through Sunday from 8:00 a.m. to 8:00 p.m. (October 1 - March 31), and Monday through Friday from 8:00 a.m. to 8:00 p.m., Saturday from 8:00 a.m. to 4:30 p.m. (April 1 - September 30).

NOTES

MCS Classicare (HMO)

Notice of availability of language assistance services and auxiliary aids and services

English: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-866-627-8183 (TTY 1-866-627-8182).

Español: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También se encuentran disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-866-627-8183 (TTY 1-866-627-8182).

Chinese: 如果您會說中文，我們可以為您提供免費語言幫助服務。也免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打 1-866-627-8183 (TTY 1-866-627-8182) 。

Tagalog: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyo sa tulong sa wika. Ang naaangkop na mga pantulong na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay makukuha rin nang walang bayad. Tumawag sa 1-866-627-8183 (TTY 1-866-627-8182).

French: Si vous parlez français, des services d’assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-866-627-8183 (TTY 1-866-627-8182).

Vietnamese: Nếu bạn nói tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Các hỗ trợ và dịch vụ phụ trợ phù hợp để cung cấp thông tin ở định dạng dễ tiếp cận cũng được cung cấp miễn phí. Gọi 1-866-627-8183 (TTY 1-866-627-8182).

German: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Auch entsprechende Hilfsmittel und Services zur Bereitstellung von Informationen in barrierefreien Formaten stehen kostenlos zur Verfügung. Rufen Sie 1-866-627-8183 (TTY 1-866-627-8182) an.

Korean: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하는 적절한 보조 지원 및 서비스도 무료로 제공됩니다. 1-866-627-8183 (TTY 1-866-627-8182) 로 전화하세요.

Russian: Если вы говорите по-русски, вам доступны бесплатные услуги языковой помощи. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по номеру 1-866-627-8183 (TTY 1-866-627-8182).

Arabic: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. تتوفر المساعدات والخدمات المساعدات المناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجاناً. اتصل بالرقم 1-866-627-8183 (TTY 1-866-627-8182).

Italian: Se parli italiano, sono a tua disposizione servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-866-627-8183 (TTY 1-866-627-8182).

Portuguese: Se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Também estão disponíveis gratuitamente ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para 1-866-627-8183 (TTY 1-866-627-8182).

French Creole: Si w pale kreyòl franse, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele 1-866-627-8183 (TTY 1-866-627-8182).

Polish: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Odpowiednie pomoce pomocnicze i usługi umożliwiające dostarczanie informacji w przystępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 1-866-627-8183 (TTY 1-866-627-8182).

Hindi: यदि आप हिंदी बोलते हैं, तो मुफ्त भाषा सहायता सेवाएं आपके लिए उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक एड्स और सेवाएं भी निःशुल्क उपलब्ध हैं। कॉल 1-866-627-8183 (TTY 1-866-627-8182).

Japanese: 日本語を話せる場合は、無料の言語支援サービスをご利用いただけます。アクセシブルな形式で情報を提供するための適切な補助援助やサービスも無料で利用できます。 1-866-627-8183 (TTY 1-866-627-8182) に電話します。

Complete Health

MCS Classicare (HMO)

Paid Endorsement. 1. Some services may require pre-authorization. Contact the plan for details. 2. Some services may require referral. 3. Pre-authorization through MCS Solutions. 4. Benefits may vary by plan. Call us or refer to your Evidence of Coverage available on our website www.mcsclassicare.com for benefit information, periodicity, limitations, and exclusions. 5. Unused amounts do not rollover to the next month or quarter as applicable. 6. The Te Paga card allowance includes your monthly OTC allowance. Enrollees who meet the eligibility criteria for Special Supplemental Benefits for the Chronically Ill (SSBCI) may use the card to purchase both OTC items and additional eligible items and services. Te Paga Card, Healthy Food Box, Transportation for non-medical needs, and Home Assistance: Eligible enrollees with chronic conditions, such as Chronic Hypertension, Cardiovascular Disorders, Diabetes Mellitus, Chronic Kidney Disease, Chronic and Disabling Mental Health Conditions, and other conditions not listed are eligible for the SSBCI program. Eligibility for the benefits described is not guaranteed solely based on the presence of a listed chronic condition. All applicable eligibility requirements must be met before the benefit is provided. For details, please contact us. 7. Te Paga Card: The benefit cannot be used for cash withdrawal nor purchase the following services or products: cosmetic procedures, hospital indemnity insurance, funeral planning and expenses, life insurance, alcohol, tobacco, cannabis products, broad membership programs inclusive of multiple unrelated services and discounts, and non-healthy food. 8. Regional product are available to beneficiaries residing in the applicable eligible municipalities. Refer to Page 32 for more details. 9. The maximum benefit amount for eyewear and hearing aids is combined and includes coverage for repairs. 10. Transportation to plan-approved locations through contracted suppliers.

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