MCS Classicare GOBIERNO AHORRO (нмо-роз) МСS Classicare ELA CRÉDITO RUBÍ (нмо-роз)

- MCS Classicare ELA ENLACE ACERO (HMO-POS)
 - MCS Classicare ELA MÁXIMO (HMO-POS)
- MCS Classicare ELA TE AYUDA (HMO-POS)

2024

MCS Classicare ELA SÓLIDO (HMO-POS)



| | BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS ELA CF |
|----------------------------|--|--|--|
| | PREMIUM, DEDUCTIBLE, AND LIMITS | | |
| | Monthly Plan Premium You must continue to pay your Medicare Part B premium | You pay \$0 | Yo |
| | Part B monthly premium reduction | \$0 monthly | \$5 |
| | Deductible | You pay nothing This plan does not have a deductible | You This plan does |
| | 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. | \$6,700 anually | \$6 |
| | HOSPITAL COVERAGE | | |
| | Inpatient Hospital coverage ¹ | In-Network: \$0 copayment for each Medicare-covered hospital stay Out-of-network (POS): | In \$0 cop Medicare-c Out-of- |
| | | 20% of the total cost | 20% o |
| | | In-Network: You pay nothing | In You |
| | Outpatient hospital services ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-l 20% o |
| | Angle Jacon Country Country (ACC) 1 | In-Network: You pay nothing | In You |
| | Ambulatory Surgical Center Services (ASC) ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-l 20% o |
| $\mathbf{\mathbf{\nabla}}$ | DOCTOR VISITS | | |
| | Primary Caro Providera | In-Network: You pay nothing | In You |
| | Primary Care Providers | Out-of-Network (POS): 20% of the total cost | Out-of-l 20% o |
| | | In-Network: You pay nothing | In You |
| | Specialists | Out-of-Network (POS): 20% of the total cost | Out-of-l 20% o |
| | Preventive Care (e.g., flu vaccine, diabetic screenings) | In-Network: You pay nothing | In You |
| | Any additional preventive services approved by Medicare during the contract year will be covered. | Out-of-Network (POS): 0% of the total cost | Out-of-l 0% of |
| | | U% of the total cost | 0% (|

1. Some services may require pre-authorization. Contact the plan for details.

Classicare RÉDITO RUBÍ (HMO-POS)



ou pay \$100

50 monthly u pay nothing es not have a deductible

,700 anually

-**Network:** ayment for each covered hospital stay

-network (POS): of the total cost

-Network: I pay nothing

Network (POS): of the total cost -Network:

ı pay nothing

Network (POS): of the total cost

-Network: I pay nothing

Network (POS): of the total cost -Network: a pay nothing Network (POS): of the total cost -Network: a pay nothing Network (POS): f the total cost You pay \$100

\$0 monthly You pay nothing This plan does not have a deductible

\$6,700 anually

In-Network: \$0 copayment for each Medicare-covered hospital stay

Out-of-network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost In-Network: You pay nothing Out-of-Network (POS):

20% of the total cost In-Network: You pay nothing

Out-of-Network (POS): 0% of the total cost

| | BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS C ELA CRÉ |
|---|--|--|-------------------------------|
| | Emergency Care Copayment is waived if you are admitted to a hospital within 24 hours. Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details. | \$25 copayment per visit | \$25 copay |
| | Urgently Needed Services Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details. | You pay nothing | You p |
| | DIAGNOSTIC SERVICES/LABS/IMAGING | | |
| H | Diagnostic tests and procedures ¹ | In-Network: 0% of the total cost Out-of-Network (POS): | In-N 0% of th Out-of-Ne |
| | Lab services ¹ | 20% of the total cost In-Network: 0% of the total cost | 20% of t In-N 0% of tl |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | Diagnostic Radiology services (e.g. MRI, CT Scan) ¹ | In-Network: 0% of the total cost | In-N 0% of th |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | N 1 | In-Network: 0% of the total cost | In-N 0% of th |
| | X-rays ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | HEARING SERVICES | | |
| | Medicara covered bearing ever | In-Network: You pay nothing | In-N You p |
| | Medicare-covered hearing exam | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | | In-Network: You pay nothing | In-N You p |
| | Routine hearing exam - one (I) annually | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | Fitting evaluation for bearing aids one (1) annually | In-Network: You pay nothing | In-N You p |
| | Fitting-evaluation for hearing aids - one (1) annually | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |

1. Some services may require pre-authorization. Contact the plan for details.

Classicare RÉDITO RUBÍ HMO-POS)

MCS Classicare ELA ENLACE ACERO (HMO-POS)

payment per visit

\$25 copayment per visit

pay nothing

You pay nothing

-Network: f the total cost

Network (POS): of the total cost -Network: of the total cost

Network (POS): of the total cost -Network: f the total cost

Network (POS): of the total cost -Network: f the total cost

Network (POS): f the total cost

-Network: a pay nothing Network (POS): of the total cost -Network: a pay nothing Network (POS):

of the total cost -Network:

pay nothing

Network (POS): of the total cost In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost In-Network: You pay nothing Out-of-Network (POS): You pay nothing Out-of-Network (POS):

20% of the total cost

| | BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS C ELA CRÉ |
|----------------|---|--|---|
| | Hearing aids ¹ | See "Combined Eyewear and Hearing Aids Allowance" | In-N You p Up to \$1,250 Out-of-Ne 0% of th |
| () | DENTAL SERVICES | | |
| | Medicare-covered services | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You p Out-of-Ne 20% of t |
| | Preventive dental services covered by Medicaid - Oral exam - Prophylaxis (cleaning) - Flouride treatment - X-rays No maximum benefit coverage applies for preventive services. | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You p Out-of-Ne 20% of t |
| | Comprehensive dental services ¹ - Crowns - Prosthodontics | In-Network: You pay nothing Up to \$2,500 annually Out-of-Network (POS): 20% of the total cost | In-N You p Up to \$3 Out-of-Ne 20% of t |
| (\mathbf{n}) | VISION SERVICES | | 20/8 01 0 |
| | Medicare-covered Eye Exam | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You p Out-of-Ne 20% of t |
| | Routine Eye Exam - one (1) annually | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You pa Out-of-Ne 20% of t |
| | Eyewear | See "Combined Eyewear and Hearing Aids Allowance" | In-N You p Up to \$8 Out-of-Ne 0% of th |
| | 1. Some services may require pre-authorization. Contact the plan for details. | | |

1. Some services may require pre-authorization. Contact the plan for details.

Classicare RÉDITO RUBÍ HMO-POS)

нмо-роs) -Network: pay nothing

50 per ear annually

Network (POS): the total cost

ELA ENLACE ACERO (HMO-POS)

MCS Classicare

See "Combined Eyewear and Hearing Aids Allowance"

-Network: 1 pay nothing Network (POS): of the total cost

You pay nothing Out-of-Network (POS): 20% of the total cost

In-Network:

-Network: pay nothing

Network (POS): f the total cost

-Network: pay nothing \$3,500 annually

Network (POS): If the total cost

-Network: pay nothing

Network (POS): f the total cost -Network: pay nothing Network (POS): f the total cost -Network:

pay nothing

\$800 annually

Network (POS):

the total cost

In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing Up to \$4,500 annually Out-of-Network (POS): 20% of the total cost

> **In-Network:** You pay nothing

Out-of-Network (POS): 20% of the total cost In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

See "Combined Eyewear and Hearing Aids Allowance"

| | / | | |
|---|----------|----------|------------------|
| (| 6 | <u>5</u> | $\left(\right)$ |
| | | 2 | ٢/ |
| | 1 | | |

MENTAL HEALTH SERVICES

Inpatient Visit²

Our plan covers up to 190 days in a lifetime for inpatient mental therapy visit health care in a psychiatric hospital.

BENEFITS

The inpatient hospital care limit does not apply to psychiatric inpatient hospital services provided in a general hospital.

Outpatient Individual Therapy Visit² Outpatient Group Therapy Visit

ADDITIONAL BENEFITS

Skilled Nursing Facility¹

Our plan covers up to 100 days. Contact the plan for details.

Physical Therapy ¹

We also cover occupational therapy, and speech and language therapy. Review the Evidence of Coverage or contact the plan for details.

Ambulance Air ambulance ¹ Ground ambulance

Transportation

A trip is considered one-way transportation medical transport to a plan approved health-related location.

In-Network: You pay nothing

MCS Classicare

GOBIERNO AHORRO

(HMO-POS)

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):**

20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):**

20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):**

20% of the total cost

In-Network: You pay nothing

In-Network: You pay nothing

For up to 18 one-way trips annually For up to 18 one-way trips annually For up to 32 one-way trips annually **Out-of-Network (POS):**

Not covered

Out-of-Network (POS): Not covered

1. Some services may require pre-authorization. Contact the plan for details. 2. Pre-authorization through MCS Solutions.

7. Transportation to plan-approved locations through contracted suppliers.

MCS Classicare **ELA CRÉDITO RUBÍ** (HMO-POS)



In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): Not covered

| | BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS CI ELA CRÉ (HM |
|--|---|--|----------------------------------|
| A State of the second s | MEDICARE PART B DRUGS | | |
| | Chemotherapy drugs ¹ | In-Network: 5% of the total cost | In-Ne 0% of the |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | | In-Network: 0% - 10% of the total cost | In-Ne 0% - 5% of |
| | Other Part B drugs ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | Insulin drugs | In-Network: 10% of the total cost maximum \$35 copayment | In-Ne 5% of the maximum \$ |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | MEDICAL EQUIPMENT / SUPPLIES | | |
| | Durable medical equipment (DME) ¹ | In-Network: You pay nothing | In-Ne You pa |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | | In-Network: 0% - 5% of the total cost | In-Ne 0% - 5% of |
| | Prosthetic devices ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | | In-Network: You pay nothing | In-Ne You pa |
| | Diabetic supplies ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Net 20% of th |
| | WELLNESS PROGRAMS | | |
| | Fitness Benefit (Club Te Paga) | In-Network: You pay nothing | In-Ne You pa |
| | Fichess Benefic (Club le Faga) | Out-of-Network (POS): Not covered | Out-of-Net Not o |
| | Nursing Hotlino (MCS Modilínos) | In-Network: You pay nothing | In-Ne You pa |
| | Nursing Hotline (MCS Medilínea) | Out-of-Network (POS): Not covered | Out-of-Net Not o |
| | 1. Some services may require pre-authorization. Contact the plan for details. | | |

Classicare ÉDITO RUBÍ

Network: the total cost

Network (POS): the total cost

Network: of the total cost

Network (POS): the total cost

Network: the total cost 1 \$35 copayment

letwork (POS): the total cost

Network: pay nothing

Network (POS): the total cost

Network: of the total cost

letwork (POS): the total cost

Network: pay nothing

letwork (POS): the total cost

Network: pay nothing

Network (POS): ot covered Network: pay nothing

Network (POS): ot covered

MCS Classicare ELA ENLACE ACERO (HMO-POS)

In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: 0% of the total cost maximum \$35 copayment

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing Out-of-Network (POS): Not covered In-Network: You pay nothing Out-of-Network (POS):

Not covered

| | BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | |
|---|--|---|--|
| | WELLNESS BENEFITS | | |
| H | Foot Exams and Treatment (Podiatry Services) | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | |
| | Foot Reflexology | In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered | |
| | Remote Access Technologies (Telemedicine) Remote Access Technologies (Telemedicine) 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 a family doctor, general practitioner, internist, or licensed pediatrician. 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. | In-Network: You pay nothing Out-of-Network (POS): Not covered | |
| | Additional Acupuncture Services | In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered | |

MCS Classicare ELA CRÉDITO RUBÍ (HMO-POS)



In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS):

Not covered

In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered

In-Network: You pay nothing Out-of-Network (POS): Not covered In-Network: You pay nothing Out-of-Network (POS): Not covered

In-Network: You pay nothing Six (6) visits annually

Out-of-Network (POS): Not covered In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered

| BENEFITS | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS C ELA CRÉ |
|---|--|---|
| SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL | | |
| 6363 01 10 1234 1234 Juan del pueblo Image: Classicare pueblo | In-Network: \$600 annually (\$50 monthly) Out-of-Network (POS): Not covered | In-N \$1,20 (\$100 Out-of-Ne Not |
| Home Assistance ^{3,5,6} Services include hairstyling, yard clean-up, plumbing, locksmith, electricity, pest control, technology assistance, and preventive home cleaning/disinfection. | In-Network: You pay nothing Twelve (12) visits annually (maximum 3 quarterly) Out-of-Network (POS): Not covered | In-N You p Twelve (12 (maximur Out-of-Ne Not |
| Transportation for non-medical needs ³ Trips used for non-medical purposes count against the maximum limit of your regular transportation benefit. | In-Network: You pay nothing Out-of-Network (POS): Not covered | In-N You p Out-of-Ne Not |
| OTHER SUPPLEMENTAL BENEFITS | | |
| Combined Eyewear and Hearing Aids Allowance ¹ | Up to \$800 annually for a combined Eyewear and Hearing Aids Allowance | |
| | | |

3. The benefits mentioned are part of a special supplemental program for members with chronic diseases. Members must meet all benefit's eligibility criteria. 4. The benefit cannot be used for cash withdrawal and to buy alcohol beverages nor tobacco, or its derivatives. 5. For hairstyling (wash, cut, and dry) services, you must visit participating establishments to receive these services. Contact the Home Assistance supplier for more details. 6. Only simple

repairs and basic services apply, according to the evaluation performed by the service supplier. Services are limited to 12 visits per year, 3 quarterly. 7. Transportation to plan-approved locations through contracted suppliers.





-Network: 200 annually 00 monthly)

Network (POS): ot covered In-Network: \$1,920 annually (\$160 monthly)

Out-of-Network (POS): Not covered

-Network: pay nothing 12) visits annually

um 3 quarterly) Network (POS): ot covered

-Network: 1 pay nothing Network (POS): ot covered

N/A

In-Network: You pay nothing Twelve (12) visits annually

(maximum 3 quarterly)

Out-of-Network (POS): Not covered

In-Network: You pay nothing Out-of-Network (POS): Not covered

Up to **\$900** annually for a combined Eyewear and Hearing Aids Allowance

| | |
|------|------|
| | |
| | ITS |
| | |

| | (HMO-POS) |
|--|--|
| REMIUM, DEDUCTIBLE, AND LIMITS | |
| Monthly Plan Premium You must continue to pay your Medicare Part B premium | You pay \$100 |
| Part B monthly premium reduction Deductible | \$101 monthly You pay nothing |
| Maximum Out-of-Pocket Responsibility (does not include prescription drugs) | This plan does not have a deductible |
| The maximum amount you pay for copays, coinsurance and other costs for in-network medical services for the year. | \$6,700 anually |
| HOSPITAL COVERAGE | |
| npatient Hospital coverage ¹ | In-Network: \$0 copayment for each Medicare-covered hospital stay |
| | Out-of-network (POS): 20% of the total cost |
| | In-Network: You pay nothing |
| Outpatient hospital services ¹ | Out-of-Network (POS): 20% of the total cost |
| | In-Network: You pay nothing |
| Ambulatory Surgical Center Services (ASC) ¹ | Out-of-Network (POS): 20% of the total cost |
| DOCTOR VISITS | |
| Primary Care Providers | In-Network: You pay nothing |
| Timary Care Froviders | Out-of-Network (POS): 20% of the total cost |
| | In-Network: You pay nothing |
| Specialists | Out-of-Network (POS): 20% of the total cost |
| Preventive Care (e.g., flu vaccine, diabetic screenings) | In-Network: You pay nothing |
| Any additional preventive services approved by Medicare during the contract year will be covered. | Out-of-Network (POS): 0% of the total cost |

1. Some services may require pre-authorization. Contact the plan for details.

MCS Classicare ELA MÁXIMO (HMO-POS)

MCS Classicare

ELA TE AYUDA



íou pay \$100

64.90 monthly u pay nothing es not have a deductible

6,700 anually

n-Network: payment for each covered hospital stay

f-network (POS): of the total cost

n-Network: u pay nothing -Network (POS): of the total cost n-Network: 60 copayment -Network (POS):

of the total cost

n-Network:

u pay nothing -Network (POS): of the total cost n-Network: 0 copayment

-Network (POS): of the total cost n-Network: u pay nothing

-Network (POS): of the total cost

You pay \$100

\$101 monthly You pay nothing This plan does not have a deductible

\$6,700 anually

In-Network: \$50 copayment for each Medicare-covered hospital stay

Out-of-network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost In-Network: \$50 copayment

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost In-Network: \$10 copayment

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 0% of the total cost

SU

| UN | IMARY OF BENEFITS | | | Access to island-wide provider network |
|--------------------|--|--|--|---|
| | BENEFITS | MCS Classicare ELA TE AYUDA (HMO-POS) | MCS Classicare ELA MÁXIMO (HMO-POS) | NEW! MCS Classicare ELA SÓLIDO (HMO-POS) |
| | Emergency Care Copayment is waived if you are admitted to a hospital within 24 hours. Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details. | \$25 copayment per visit | \$75 copayment per visit | \$75 copayment per visit |
| | Urgently Needed Services Some plan rules and requirements may apply for post-stabilization care. Contact the plan for details. | You pay nothing | \$10 copayment per visit | \$10 copayment per visit |
| $\left(1 \right)$ | DIAGNOSTIC SERVICES/LABS/IMAGING | | | |
| E / | | In-Network: 0% of the total cost | In-Network: 20% of the total cost | In-Network: 20% of the total cost |
| | Diagnostic tests and procedures ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | | In-Network: 0% of the total cost | In-Network: 20% of the total cost | In-Network: 20% of the total cost |
| | Lab services ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | | In-Network: 0% of the total cost | In-Network: 20% of the total cost | In-Network: 20% of the total cost |
| | Diagnostic Radiology services (e.g. MRI, CT Scan) ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | × 1 | In-Network: 0% of the total cost | In-Network: 20% of the total cost | In-Network: 20% of the total cost |
| | X-rays ¹ | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | HEARING SERVICES | | | |
| | | In-Network: You pay nothing | In-Network: You pay nothing | In-Network: You pay nothing |
| | Medicare-covered hearing exam | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | | In-Network: You pay nothing | In-Network: You pay nothing | In-Network: You pay nothing |
| | Routine hearing exam - one (I) annually | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |
| | | In-Network: You pay nothing | In-Network: You pay nothing | In-Network: You pay nothing |
| | Fitting-evaluation for hearing aids - one (1) annually | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost | Out-of-Network (POS): 20% of the total cost |

1. Some services may require pre-authorization. Contact the plan for details.

| | BENEFITS | MCS Classicare ELA TE AYUDA (HMO-POS) | MCS C ELA N (HM |
|-----------------|---|--|---|
| \frown | Hearing aids ¹ | See "Combined Eyewear and Hearing Aids Allowance" | See "Combined I Aids A |
| (\mathbf{m}) | DENTAL SERVICES | | |
| | Medicare-covered services | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You pa Out-of-Ne 20% of t |
| | Preventive dental services covered by Medicaid - Oral exam - Prophylaxis (cleaning) - Flouride treatment - X-rays | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You pa Out-of-Ne 20% of t |
| | No maximum benefit coverage applies for preventive services. | | |
| | Comprehensive dental services ¹ | In-Network: You pay nothing | In-N You pa |
| \frown | - Crowns - Prosthodontics | Up to \$3,000 annually Out-of-Network (POS): 20% of the total cost | Up to \$2 Out-of-Ne 20% of t |
| (\mathbf{OO}) | VISION SERVICES | | |
| | Medicare-covered Eye Exam | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-N You pa Out-of-Ne 20% of t |
| | Routine Eye Exam - one (1) annually | In-Network: You pay nothing | In-N You pa |
| | | Out-of-Network (POS): 20% of the total cost | Out-of-Ne 20% of t |
| | Eyewear | See "Combined Eyewear and Hearing Aids Allowance" | See "Combined I Aids A |
| | 1. Some services may require pre-authorization. Contact the plan for details. | 8. Access to the provider's network all over Puerto F Evidence of Coverage or contact the plan. | Rico. The service area for |

Classicare MÁXIMO IMO-POS)



Allowance"

d Eyewear and Hearing See "Combined Eyewear and Hearing Aids Allowance"

Network: pay nothing Network (POS): the total cost

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

-Network: pay nothing Network (POS): the total cost

Network: pay nothing \$2,000 annually Network (POS): the total cost

-Network: pay nothing Network (POS): the total cost -Network: pay nothing Network (POS): the total cost

Allowance"

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

> In-Network: You pay nothing

Up to \$2,000 annually

Out-of-Network (POS): 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

d Eyewear and Hearing See "Combined Eyewear and Hearing" Aids Allowance"

for MCS Classicare ELA Sólido includes 39 municipalities. For details see the



BENEFITS

| | | (| (|
|-------|---|---|---|
|))))) | MENTAL HEALTH SERVICES | | |
| | Inpatient Visit ² 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. | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-Ne \$50 copaym Out-of-Net 20% of the |
| | Outpatient Individual Therapy Visit ² Outpatient Group Therapy Visit | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-Ne You pay Out-of-Net 20% of the |
| | ADDITIONAL BENEFITS | | |
| | Skilled Nursing Facility ¹ Our plan covers up to 100 days. Contact the plan for details. | In-Network: You pay nothing Out-of-Network (POS): | In-Ne You pay Out-of-Net |
| | | 20% of the total cost | 20% of the |
| | Physical Therapy ¹ We also cover occupational therapy, and speech and language therapy. Review the Evidence of Coverage or contact the plan for details. | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-Ne You pay Out-of-Net 20% of the |
| | Ambulance Air ambulance ¹ Ground ambulance | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-Ne You pay Out-of-Net 20% of the |
| | Transportation A trip is considered one-way transportation medical transport to a plan approved health-related location. | In-Network: You pay nothing For up to 16 one-way trips annually Out-of-Network (POS): Not covered | In-Ne You pay For up to 12 one Out-of-Net Not c |
| | 1 Some services may require pre-authorization. Contact the plan for details 2 Pre-authorization through MCS Solutions | 8 Access to the provider's natwork all over Puerto | Pica. The convice area for M |

1. Some services may require pre-authorization. Contact the plan for details. 2. Pre-authorization through MCS Solutions. 7. Transportation to plan-approved locations through contracted suppliers.

8. Access to the provider's network all over Puerto Rico. The service area for MCS Classicare ELA Sólido includes 39 municipalities. For details see the Evidence of Coverage or contact the plan.



MCS Classicare

ELA TE AYUDA (HMO-POS)

Access to island-wide provider network NEW! **MCS Classicare ELA SÓLIDO** (HMO-POS)

etwork: ment per visit etwork (POS): the total cost

In-Network: \$50 copayment per visit **Out-of-Network (POS):** 20% of the total cost

etwork: bay nothing etwork (POS): the total cost

letwork: ay nothing etwork (POS): the total cost

letwork: ay nothing

etwork (POS): the total cost

letwork: bay nothing

etwork (POS): the total cost

letwork: ay nothing etwork (POS): covered

In-Network: You pay nothing **Out-of-Network (POS):** 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):**

20% of the total cost

In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing e-way trips annually For up to 12 one-way trips annually **Out-of-Network (POS):** Not covered

| A contraction | |
|---------------|--|
| | |

BENEFITS

| | BENEFITS | ELA TE AYUDA (HMO-POS) | |
|----------------|---|---|---|
| | MEDICARE PART B DRUGS | | |
| | Chemotherapy drugs ¹ | In-Network: 0% of the total cost Out-of-Network (POS): 20% of the total cost | In-I 5% of t Out-of-N 20% of |
| | Other Part B drugs ¹ | In-Network: 0% of the total cost Out-of-Network (POS): 20% of the total cost | In-N 0% - 10% Out-of-N 20% of |
| | Insulin drugs | Dentro de la red: 0% del costo total, máximo \$35 copago Fuera de la red (POS): | In-I 10% of maximum Out-of-N |
| \overline{z} | | 20% del costo total | 20% of |
| ர | MEDICARE PART B DRUGS Chemotherapy drugs 1 Other Part B drugs 1 | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-۱ ۲ou ۲ Out-of-N 20% of |
| | Prosthetic devices ¹ | In-Network: 0% of the total cost Out-of-Network (POS): | in-۱ 0% of t Out-of-N |
| | Diabetic supplies ¹ | 20% of the total cost In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | 20% of اn-۱ You ہ Out-of-N 20% of |
| | WELLNESS PROGRAMS | | 20/0 01 |
| Ц | Fitness Benefit (Club Te Paga) | In-Network: You pay nothing | In-Ի You բ |
| | | Out-of-Network (POS): Not covered | Out-of-N No |
| | Nursing Hotline (MCS Medilínea) | In-Network: You pay nothing Out-of-Network (POS): Not covered | in-۱ ۲ou ۲ Out-of-N |
| | 1. Some services may require pre-authorization. Contact the plan for details. | 8. Access to the provider's network all over Puerto R | No lico. The service area fo |

MCS Classicare ELA MÁXIMO (HMO-POS)

MCS Classicare

Evidence of Coverage or contact the plan.

-Network: of the total cost

Network (POS): of the total cost

-Network: % of the total cost

Network (POS): of the total cost

n-Network: of the total cost m \$35 copayment

Network (POS): of the total cost

n-Network: u pay nothing

Network (POS): of the total cost

-Network: f the total cost

Network (POS): of the total cost

n-Network: u pay nothing

Network (POS): of the total cost

n-Network: u pay nothing

Network (POS): lot covered -Network: u pay nothing

Network (POS): lot covered

Access to island-wide provider network NEW! MCS Classicare **ELA SÓLIDO** (HMO-POS)

> In-Network: 5% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: 0% - 10% of the total cost

Out-of-Network (POS): 20% of the total cost

In-Network: 10% of the total cost maximum \$35 copayment

Out-of-Network (POS): 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

> In-Network: 0% of the total cost

Out-of-Network (POS): 20% of the total cost

> In-Network: You pay nothing

Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing **Out-of-Network (POS):** Not covered In-Network: You pay nothing **Out-of-Network (POS):** Not covered 8. Access to the provider's network all over Puerto Rico. The service area for MCS Classicare ELA Sólido includes 39 municipalities. For details see the

| 2 | BENEFITS | MCS Classicare ELA TE AYUDA (HMO-POS) | MCS Cla ELA M (HMO |
|---|--|---|--|
| | WELLNESS BENEFITS | | |
| | Foot Exams and Treatment (Podiatry Services) | In-Network: You pay nothing Out-of-Network (POS): 20% of the total cost | In-Net \$10 copaym Out-of-Net 20% of the |
| | Foot Reflexology | In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered | In-Ne t You pay Six (6) visi Out-of-Net Not co |
| | Remote Access Technologies (Telemedicine) Remote Access Technologies (Telemedicine) 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 a family doctor, general practitioner, internist, or licensed pediatrician. 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. | In-Network: You pay nothing Out-of-Network (POS): Not covered | In-Net You pay Out-of-Net Not co |
| | Additional Acupuncture Services | In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered | In-Ne r You pay Six (6) visi Out-of-Net Not co |
| | | 8. Access to the provider's network all over Puerto R | ico. The service area for M |

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Access to island-wide provider network NEW! MCS Classicare ELA SÓLIDO (HMO-POS)

Network: syment per visit Network (POS): the total cost

Network: pay nothing visits annually Network (POS): ot covered In-Network: \$10 copayment per visit Out-of-Network (POS): 20% of the total cost

In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered

Network: pay nothing Network (POS): pt covered In-Network: You pay nothing Out-of-Network (POS): Not covered

Network: pay nothing visits annually

Network (POS): ot covered

Evidence of Coverage or contact the plan.

In-Network: You pay nothing Six (6) visits annually Out-of-Network (POS): Not covered

or MCS Classicare ELA Sólido includes 39 municipalities. For details see the

| BENEFITS | MCS Classicare ELA TE AYUDA (HMO-POS) | MCS C ELA N (HM |
|---|---|--|
| SPECIAL SUPPLEMENTAL BENEFITS FOR THE CHRONICALLY ILL | | |
| Gassicare Te Paga Card 3,4 Man del pueblo State | In-Network: \$780 annually (\$65 monthly) Out-of-Network (POS): Not covered | In-N \$360 (\$30 Out-of-Ne Not |
| Home Assistance ^{3,6} Services include hairstyling ⁵ , yard clean-up, plumbing, locksmith, electricity, pest control, technology assistance, and preventive home cleaning/disinfection. | In-Network: You pay nothing Doce (12) visitas anualmente (máximo 3 trimestrales) Out-of-Network (POS): Not covered | In-N You pa Doce (12) vis (máximo 3 Out-of-Ne Not |
| Transportation for non-medical needs ^{3,7} Trips used for non-medical purposes count against the maximum limit of your regular transportation benefit. | In-Network: You pay nothing Out-of-Network (POS): Not covered | In-N You pa Out-of-Ne Not |
| OTHER SUPPLEMENTAL BENEFITS | | |
| Combined Eyewear and Hearing Aids Allowance ¹ | Up to \$700 annually for a combined Eyewear and Hearing Aids Allowance | Up to \$800 annu Eyewear and Hea |
| | | |

3. The benefits mentioned are part of a special supplemental program for members with chronic diseases. Members must meet all benefit's eligibility criteria. 4. The benefit cannot be used for cash withdrawal and to buy alcohol beverages nor tobacco, or its derivatives. 5. For hairstyling (wash, cut, and dry) services, you must visit participating establishments to receive these services. Contact the Home Assistance supplier for more details. 6. Only simple repairs and basic services apply, according to the evaluation performed by the service supplier. Services are limited to 12 visits per year, 3 quarterly.

7. Transportation to plan-approved locations through contracted suppliers. 8. Access to the provider's network all over Puerto Rico. The service area for MCS Classicare ELA Sólido includes 39 municipalities. For details see the Evidence of Coverage or contact the plan. 9. Unused amounts do not rollover to the next month or quarter.



Access to island-wide provider network NEW! MCS Classicare ELA SÓLIDO (HMO-POS)

-Network: 60 annually 30 monthly)

Network (POS): ot covered

In-Network: \$1,200 annually (\$100 monthly)

Out-of-Network (POS): Not covered

Network: pay nothing visitas anualmente o 3 trimestrales) Network (POS):

ot covered

-Network: pay nothing Network (POS): ot covered In-Network: You pay nothing Doce (12) visitas anualmente (máximo 3 trimestrales)

Out-of-Network (POS): Not covered

In-Network: You pay nothing Out-of-Network (POS): Not covered

nually for a combined learing Aids Allowance Up to **\$600** annually for a combined Eyewear and Hearing Aids Allowance

PRESCRIPTION DRUGS

| STAGE | DRUG TIER | MCS Classicare GOBIERNO AHORRO (HMO-POS) | MCS Classicare ELA CRÉDITO RUBÍ (HMO-POS) | MCS Classicare ELA ENLACE ACERO (HMO-POS) |
|--|--|---|---|---|
| DEDUCIBLE ANUAL | Because there is no deductible for the plan, this payment stage does not apply to you. | \$0 сорау | \$0 сорау | \$0 сорау |
| | STANDARD RETAIL (IN-NETWORK) (30-DAY SUPPLY) | | | |
| | Tier I - Preferred Generic | \$0 сорау | \$0 copay | \$0 сорау |
| | Tier 2 - Generic | \$0 copay | \$0 copay | \$0 сорау |
| | Tier 3 - Preferred Brand | \$0 сорау | \$4 copay | \$0 copay |
| | Tier 4 - Non-Preferred Brand | \$5 copay | \$8 copay | \$0 сорау |
| | Tier 5 - Specialty Drugs | 25% of the total cost | 25% of the total cost | 25% of the total cost |
| | Tier 6 - Select Care Drugs | \$0 сорау | \$0 copay | \$0 сорау |
| INITIAL COVERAGE | STANDARD RETAIL (IN-NETWORK) (90-DAY SUPPLY) | | | |
| | Tier I - Preferred Generic | \$0 сорау | \$0 copay | \$0 сорау |
| During this stage, the | Tier 2 - Generic | \$0 сорау | \$0 copay | \$0 сорау |
| plan pays its share of the | Tier 3 - Preferred Brand | \$0 сорау | \$12 copay | \$0 сорау |
| total cost of your drugs | Tier 4 - Non-Preferred Brand | \$15 copay | \$24 copay | \$0 сорау |
| the total cost. You stay in | Tier 5 - Specialty Drugs | Not offered | Not offered | Not offered |
| this stage until your year- | Tier 6 - Select Care Drugs | \$0 сорау | \$0 copay | \$0 copay |
| to-date total costs (your | MAIL-ORDER (UP TO A 90-DAY SUPPLY) | | | |
| payments plus any Part D plan's payments) total | | \$0 сорау | \$0 copay | \$0 сорау |
| \$5,030. | Tier 2 - Generic | \$0 сорау | \$0 copay | \$0 сорау |
| | Tier 3 - Preferred Brand | \$0 сорау | \$8 copay | \$0 сорау |
| | Tier 4 - Non-Preferred Brand | \$10 copay | \$16 copay | \$0 copay |
| | Tier 5 - Specialty Drugs | Not offered | Not offered | Not offered |
| | Tier 6 - Select Care Drugs | \$0 copay | \$0 сорау | \$0 copay |
| COVERAGE GAP | After your total drug costs (including what our plan has paid and what you have paid) reach \$5,030, you will pay the same copays mentioned above for Tiers 1, 2 and 6 and no more than 25% coinsurance for brand name drugs. You stay in this stage until your year-to-date out-of-pocket costs (your payments) reach a total of \$8,000. | our Call center for more information. Important Message About What You Pay for Insulin - You won't pay more than \$0 for a one-month supply of insulin product covered by our plan, no matter what cost-sharing tier it's on. Getting Help from Medicare - If you chose this plan because you were looking for insulin coverage at \$35 or less a n it is important to know that you may have other options available to you for 2023 at even lower costs because of change the Medicare Part D program. Contact Medicare, at I-800-MEDICARE (I-800-633-4227), 24 hours a day, 7 days a weight the Medicare Part D program. | | |
| CATASTROPHIC COVERAGE | You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$8,000 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, the plan pays the full cost for your covered drugs. You pay nothing. | | | |

Cost-sharing may differ for LongTerm Care (LTC) pharmacies, home infusion pharmacies, and out-of-network pharmacies. Cost-sharing may also change when you enter into another phase of the Part D benefit. Please see your Evidence of Coverage for details.

Additional Resources to Help - Please contact our Call Center number at 787-620-2530 (Metro Area) or 1-866627-8183 (Toll Free) for additional information. (TTY users should call 1-866-627-8182.) Hours are from October 1st through March 31st: Monday through Sunday from 8:00 a.m. to 8:00 p.m., and from April 1st through September 30th: Monday through Friday from 8:00 a.m. to 8:00 p.m.; Saturday from 8:00 a.m. to 4:30 p.m.

| YKESCK | IPTION DRUGS | | | Access to island-wide provider network |
|--|---|--|---|---|
| STAGE | DRUG TIER | MCS Classicare ELA TE AYUDA (HMO-POS) | MCS Classicare ELA MÁXIMO (HMO-POS) | NEW! MCS Classicare ELA SÓLIDO (HMO-POS) |
| YEARLY DEDUCTIBLE | Because there is no deductible for the plan, this payment stage does not apply to you. | \$0 copay | \$0 copay | \$0 copay |
| | STANDARD RETAIL (IN-NETWORK) (30-DAY SUPPLY) | | | |
| 興 | Tier I - Preferred Generic | \$0 copay | \$0 copay | \$0 copay |
| | Tier 2 - Generic | \$0 copay | \$0 copay | \$0 copay |
| | Tier 3 - Preferred Brand | \$2 copay | \$5 copay | \$0 copay |
| \Box | Tier 4 - Non-Preferred Brand | \$4 copay | \$10 copay | \$0 copay |
| | Tier 5 - Specialty Drugs | 25% of the total cost | 33% of the total cost | 33% of the total cost |
| | Tier 6 - Select Care Drugs | \$0 copay | \$0 copay | \$0 сорау |
| NITIAL COVERAGE | STANDARD RETAIL (IN-NETWORK) (90-DAY SUPPLY) | | | |
| | Tier I - Preferred Generic | \$0 copay | \$0 copay | \$0 copay |
| uring this stage, the | Tier 2 - Generic | \$0 copay | \$0 copay | \$0 copay |
| an pays its share of the | Tier 3 - Preferred Brand | \$6 copay | \$15 copay | \$0 copay |
| nd you pay your share of | Tier 4 - Non-Preferred Brand | \$12 copay | \$30 copay | \$0 copay |
| | Tier 5 - Specialty Drugs | Not offered | Not offered | Not offered |
| is stage until your year- | Tier 6 - Select Care Drugs | \$0 copay | \$0 copay | \$0 сорау |
| -date total costs (your | | | | |
| yments plus any Part | Tier I - Preferred Generic | \$0 copay | \$0 copay | \$0 copay |
| 5,030. | Tier 2 - Generic | \$0 copay | \$0 copay | \$0 copay |
| | Tier 3 - Preferred Brand | \$4 copay | \$10 copay | \$0 copay |
| | Tier 4 - Non-Preferred Brand | \$8 copay | \$20 copay | \$0 copay |
| | Tier 5 - Specialty Drugs | Not offered | Not offered | Not offered |
| | Tier 6 - Select Care Drugs | \$0 copay | \$0 copay | \$0 сорау |
| COVERAGE GAP | After your total drug costs (including what our plan has paid and what you have paid) reach \$5,030, you will pay the same copays mentioned above for Tiers 1, 2 and 6 and no more than 25% coinsurance for brand name drugs. You stay in this stage until your year- | Important Message About What You Pay for Vaccines - Our plan covers most our Call center for more information. | | , |
| | to-date out-of-pocket costs (your payments) reach a total of \$8,000. | Important Message About What You Pay for Insulin - You won't pay more than \$0 for a one-month supply of insulin product covered by our plan, no matter what cost-sharing tier it's on. | | |
| CATASTROPHIC COVERAGE You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$8,000 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, the plan pays the full cost for your covered drugs. You pay nothing. | | | at even lower costs because of changes t | |
| | | | | |

Cost-sharing may differ for LongTerm Care (LTC) pharmacies, home infusion pharmacies, and out-of-network pharmacies. Cost-sharing may also change when you enter into another phase of the Part D benefit. Please see your Evidence of Coverage for details.

Additional Resources to Help - Please contact our Call Center number at 787-620-2530 (Metro Area) or 1-866627-8183 (Toll Free) for additional information. (TTY users should call 1-866-627-8182.) Hours are from October 1st through March 31st: Monday through Sunday from 8:00 a.m. to 8:00 p.m., and from April 1st through September 30th: Monday through Friday from 8:00 a.m. to 8:00 p.m.

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

January 1, 2024 - December 31, 2024

MCS Classicare is a product subscribed by MCS Advantage, Inc. MCS Classicare is an HMO plan with a Medicare contract. Enrollment in MCS Classicare depends on contract renewal.

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 <u>www.mcsclassicare.com</u> to view your 2024 Evidence of Coverage.

To join an MCS Classicare plan you must have Medicare Part A, be enrolled in Medicare Part B, and live in our service area. You are also eligible for membeTrship in our plan as long as you are a United States citizen or are lawfully present in the United States or you were a member of a different plan that was terminated.

For MCS Classicare Gobierno Ahorro (HMO-POS), MCS Classicare ELA Crédito Rubí (HMO-POS), MCS Classicare ELA Enlace Acero (HMO-POS), MCS Classicare ELA Te Ayuda (HMO-POS) and MCS Classicare ELA Máximo (HMO-POS) our service area includes the following municipalities in Puerto Rico:

Adjuntas, Aguada, Aguadilla, Aguas Buenas, Aibonito, Añasco, Arecibo, Arroyo, Barceloneta, Barranquitas, Bayamón, Cabo Rojo, Caguas, Camuy, Canóvanas, Carolina, Cataño, Cayey, Ceiba, Ciales, Cidra, Coamo, Comerío, Corozal, Culebra, Dorado, Fajardo, Florida, Guánica, Guayama, Guayanilla, Guaynabo, Gurabo, Hatillo, Hormigueros, Humacao, Isabela, Jayuya, Juana Díaz, Juncos, Lajas, Lares, Las Marías, Las Piedras, Loíza, Luquillo, Manatí, Maricao, Maunabo, Mayagüez, Moca, Morovis, Naguabo, Naranjito, Orocovis, Patillas, Peñuelas, Ponce, Quebradillas, Rincón, Río Grande, Sabana Grande, Salinas, San Germán, San Juan, San Lorenzo, San Sebastián, Santa Isabel, Toa Alta, Toa Baja, Trujillo Alto, Utuado, Vega Alta, Vega Baja, Vieques, Villalba, Yabucoa and Yauco.

For MCS Classicare ELA Sólido (HMO-POS), our service area includes the following municipalities in Puerto Rico:

Adjuntas, Aguada, Aguadilla, Añasco, Arecibo, Barceloneta, Cabo Rojo, Camuy, Ciales, Corozal, Florida, Guánica, Guayanilla, Hatillo, Hormigueros, Isabela, Jayuya, Juana Díaz, Lajas, Lares, Las Marías, Manatí, Maricao, Mayagüez, Moca, Morovis, Orocovis, Peñuelas, Ponce, Quebradillas, Rincón, Sabana Grande, San Germán, San Sebastián, Utuado, Vega Alta, Vega Baja, Villalba and Yauco.

MCS Classicare 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.

MCS Classicare (HMO-POS) has a network of doctors, hospitals, pharmacies, and other providers. For some services you can use providers that are not in our network (Point of Service, POS). This benefit is covered by reimbursement. Out-of-network/non-contracted providers are under no obligation to treat MCS Classicare members, except in emergency situations. Coverage for services received out-of-network is managed through reimbursement based on the different fee shedules allowed by our plan, which are applied according to the service received, less the corresponding cost-sharing amount. Please call our Call Center number or see your Evidence of Coverage for more information, including the cost-sharing that applies to out-of network services.

Approved by the Puerto Rico Health Insurance Administration.

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 <u>http://www.medicare.gov</u> or get a copy by calling I-800-MEDICARE (I-800-633-4227), 24 hours a day, 7 days a week.TTY users should call I-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 toll free 1-866-627-8181.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 I 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**

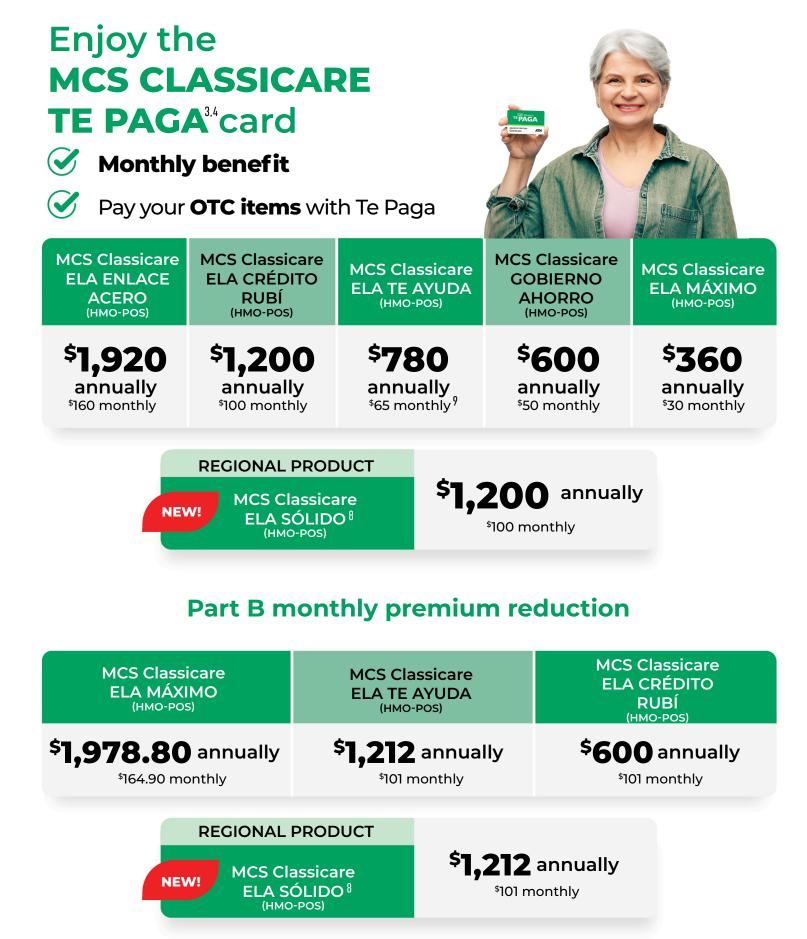
Plan Directories

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

You can see the complete plan formulary (list of Part at **www.mcsclassicare.com**



With MCS Classicare **ELA Enlace Acero (HMO-POS) you have:**



Comprehensive dental

\$4.500 every year **Restorative Services • Crowns • Prosthodontics**

per year

Eyewear and hearing aids

Combined benefit

over Puerto Rico. The service area for MCS Classicare ELA Sólido includes 39 municipalities. For details see the Evidence of Coverage or contact the plan. 9. Unused amounts do not rollover to the next month or quarter.

1. Some services may require pre-authorization. Contact the plan for details. 3. The benefits mentioned are part of a special supplemental program for members with chronic diseases. Members must meet all benefit's eligibility criteria. 4. The benefit cannot be used for cash withdrawal and to buy alcohol beverages nor tobacco, or its derivatives. 7. Transportation to plan-approved locations through contracted suppliers. 8. Access to the provider's network all

Generic and brand-name drugs ^{\$}0 copay



Transportation 32 one way trips

annual



Salud Completa MED Classicare PENSIONADO DE GOBIERNO (HMO)

By calling this number you will be able to communicate with an Authorized Sales Representative.





Monday through Sunday from 8:00 a.m. a 8:00 p.m. from Octuber 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday 8:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 4:30 p.m.

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1.866.627.8182

TTY (Hearing Impaired)