



Summary of Benefits for CCM Direct Complete and CCM Direct Advantage

H5989 Comprehensive Care Management Corporation
January 1, 2010 - December 31, 2010

Welcome to CCM Direct Complete and CCM Direct Advantage

Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk and Westchester Counties, State of New York

Call a CCM Direct representative today to help you understand your Medicare benefits and the choices available to you.

Toll free 1-877-226-8500 (TTY users, 1-800-650-2774).

Monday, Tuesday, Wednesday, Thursday and Friday, 8:00 am to 8:00 pm Eastern Standard Time

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Section I – Introduction to Summary of Benefits

Thank you for your interest in CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO). Our Plans are offered by COMPREHENSIVE CARE MANAGEMENT CORP., a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. These Plans are designed for people who meet specific enrollment criteria.

If you reside in a nursing home you may be eligible to join this Plan. Please call CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction. This Summary of Benefits tells you some features of our Plans. It doesn't list every service we cover or list every limitation or exclusion. To get a complete list of our benefits, please call CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) and ask for the "Evidence of Coverage".

▶ **YOU HAVE CHOICES IN YOUR HEALTH CARE**

As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like CCM Direct Complete Plan (HMO) or CCM Direct Advantage Plan (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

If you are living in a nursing home or you live in the community or in an assisted living facility and require the same level of care as someone in a nursing home, you may join or leave a Plan at any time.

Please call CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) at the number listed at the end of this introduction or 1-800-MEDICARE (1-800-633-4227) for more information. TTY/TDD users should call 1-877-486-2048. You can call this number 24 hours a day, 7 days a week.

▶ **HOW CAN I COMPARE MY OPTIONS?**

You can compare CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) with the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our Plan covers and what the Original Medicare Plan covers.

Our members receive all of the benefits that the Original Medicare Plan offers. We also offer more benefits, which may change from year to year.

▶ **WHERE ARE CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) AVAILABLE?**

The service area for this Plan includes: Bronx, Kings, New York, Queens, Westchester, Nassau, Richmond, Suffolk Counties, NY. You must live in one of these areas to join the Plan.

▶ **WHO IS ELIGIBLE TO JOIN CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO)?**

You can join CCM Direct Complete Plan (HMO) or CCM Direct Advantage Plan (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End Stage Renal Disease generally are not eligible to enroll in CCM Direct Complete Plan (HMO) or CCM Direct Advantage Plan (HMO) unless they are members of our organization and have been since their dialysis began. If you are a resident of a nursing home you may be eligible to join the Plan if you reside or agree to reside in a nursing home that has a contract with this health plan. You must live in one of CCM's contracted facilities to join this Plan. Please call the Plan to see if you are eligible to join.

▶ **CAN I CHOOSE MY DOCTORS?**

CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) have formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time. You can ask for a current Provider Directory or for an up-to-date list visit us at www.ccmny.org. Our customer service number is listed at the end of this introduction.

▶ **WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?**

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither CCM Direct Complete Plan (HMO), CCM Direct Advantage Plan (HMO) or the Original Medicare Plan will pay for these services.

▶ **DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?**

CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

▶ **WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?**

CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) have formed a network of pharmacies. You must use a network pharmacy to receive Plan benefits. We may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases. The pharmacies in our network can change at any time. You can ask for a pharmacy directory or visit us at www.ccmny.org. Our customer service number is listed at the end of this introduction.

▶ **WHAT IS A PRESCRIPTION DRUG FORMULARY?**

CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) use a formulary. A formulary is a list of drugs covered by your Plan to meet patient needs. We may periodically add, remove, or make changes to coverage limitations on certain drugs or change how much you pay for a drug. If we make any formulary change that limits our members' ability to fill their prescriptions, we will notify the effected enrollees before the change is made. We will send a formulary to you and you can see our complete formulary on our web site at www.ccmny.org.

If you are currently taking a drug that is not on our formulary or subject to additional requirements or limits, you may be able to get a temporary supply of the drug. You can contact us to request an exception or switch to an alternative drug listed on our formulary with your physician's help. Call us to see if you can get a temporary supply of the drug or for more details about our drug transition policy.

▶ HOW CAN I GET EXTRA HELP WITH MY PRESCRIPTION DRUG PLAN COSTS?

You may be able to get extra help to pay for your prescription drug premiums and costs. To see if you qualify for getting extra help, call:

- * 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048, 24 hours a day/7 days a week
- * The Social Security Administration at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY/TDD users should call 1-800-325-0778 or
- * Your State Medicaid Office.

▶ WHAT ARE MY PROTECTIONS IN THIS PLAN?

All Medicare Advantage Plans agree to stay in the program for a full year at a time. Each year, the plans decide whether to continue for another year. Even if a Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue, it must send you a letter at least 90 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of CCM Direct Complete Plan (HMO) or CCM Direct Advantage Plan (HMO), you have the right to request an organization determination, which includes the right to file an appeal if we deny coverage for an item or service, and the right to file a grievance. You have the right to request an organization determination if you want us to provide or pay for an item or service that you believe should be covered. If we deny coverage for your requested item or service, you have the right to appeal and ask us to review our decision. You may ask us for an expedited (fast) coverage determination or appeal if you believe that waiting for a decision could seriously put your life or health at risk, or affect your ability to regain maximum function. If your doctor makes or supports the expedited request, we must expedite our decision. Finally, you have the right to file a grievance with us if you have any type of problem with us or one of our network providers that does not involve coverage for an item or service. If your problem involves quality of care, you also have the right to file a grievance with the Quality Improvement Organization (QIO) for your state, Island Peer Review Organization (IPRO) at 1-800-331-7767.

As a member of CCM Direct Complete Plan (HMO) or CCM Direct Advantage Plan (HMO), you have the right to request a coverage determination, which includes the right to request an exception, the right to file an appeal if we deny coverage for a prescription drug, and the right to file a grievance. You have the right to request a coverage determination if you want us to cover a Part D drug that you believe should be covered. An exception is a type of coverage determination. You may ask us for an exception if you believe you need a drug that is not on our list of covered drugs or believe you should get a non-preferred drug at a lower out-of-pocket cost. You can also ask for an exception to cost utilization rules, such as a limit on the quantity of a drug. If you think you need an exception, you should contact us before you try to fill your prescription at a pharmacy. Your doctor must provide a statement to support your exception request. If we deny coverage for your prescription drug(s), you have the right to appeal and ask us to review our decision. Finally, you have the right to file a grievance if you have any type of problem with us or one of our network pharmacies that does not involve coverage for a prescription drug.

▶ WHAT IS A MEDICATION THERAPY MANAGEMENT (MTM) PROGRAM?

A Medication Therapy Management (MTM) Program is a free service we may offer. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate but it is recommended that you take full advantage of this covered service if you are selected. Contact CCM Direct Complete Plan (HMO) and CCM Direct Advantage Plan (HMO) for more details.

▶ WHAT TYPES OF DRUGS MAY BE COVERED UNDER MEDICARE PART B?

Some outpatient prescription drugs may be covered under Medicare Part B. These may include, but are not limited to, the following types of drugs. Contact CCM Direct Plan (HMO) for more details.

- Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
- Osteoporosis Drugs: Injectable drugs for osteoporosis for certain women with Medicare.
- Erythropoietin (Epoetin Alfa or Epogen®): By injection if you have end-stage renal disease (permanent kidney failure requiring either dialysis or transplantation) and need this drug to treat anemia.
- Hemophilia Clotting Factors: Self-administered clotting factors if you have hemophilia.
- Injectable Drugs: Most injectable drugs administered incident to a physician's service.
- Immunosuppressive Drugs: Immunosuppressive drug therapy for transplant patients if the transplant was paid for by Medicare, or paid by a private insurance that paid as a primary payer to your Medicare Part A coverage, in a Medicare-certified facility.
- Some Oral Cancer Drugs: If the same drug is available in injectable form.
- Oral Anti-Nausea Drugs: If you are part of an anti-cancer chemotherapeutic regimen.
- Inhalation and Infusion Drugs provided through DME.

▶ PLAN RATINGS

The Medicare program rates how well plans perform in different categories (for example, detecting and preventing illness, ratings from patients and customer service). If you have access to the web, you may use the web tools on www.medicare.gov and select "Compare Medicare Prescription Drug Plans" or "Compare Health Plans and Medigap Policies in Your Area" to compare the plan ratings for Medicare plans in your area. You can also call us directly at 1-877-266-8500 to obtain a copy of the plan ratings for this Plan. TTY users call 1-800-650-2774.

Please call Comprehensive Care Management Corp. for more information our Plans.
CCM Direct Complete Plan and CCM Direct Advantage Plan
Visit us at www.ccmny.org or call us:

Customer Service Hours
Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday 8:00 am to 8:00 EST.

Current and prospective members should call 1-877-226-8500, (TTY/TDD 1-800-650-2774) for questions related to the Medicare Advantage program.

Current and prospective members should call locally (718) 515-8600 for questions related to the Medicare Advantage program.
(TTY/TDD 800-650-2774)

Current members and prospective should call 1-877-226-8500, (TTY/TDD 1-800-650-2774) for questions related to the Medicare Part D Prescription Drug program.

Current and prospective members should call locally (718) 515-8600 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 800-650-2774)

For more information about Medicare, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
You can call 24 hours a day, 7 days a week. Or, visit www.Medicare.gov on the web.

If you have special needs, this document may be available in other formats.

If you have any questions about this Plan's benefits or costs, please contact Comprehensive Care Management Corp. for details.

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SUMMARY OF BENEFITS			
BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>1- Premium and Other Important Information</p>	<p>Most Medicare beneficiaries will continue to pay the same \$96.40 Part B premium amount in 2010 and the yearly deductible amount is \$155.</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General \$33.30 monthly Plan premium in addition to your monthly Medicare Part B premium.</p>	<p>General \$33.30 monthly Plan premium in addition to your monthly Medicare Part B premium.</p> <p>In-Network \$3,400 out-of-pocket limit.</p> <p>All Plan services included.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>2 - Doctor and Hospital Choice (For more information, see Emergency - #15 and Urgently Needed Care - #16.)</p>	<p>You may go to any doctor, specialist or hospital that accepts Medicare.</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>	<p>In-Network You must go to network doctors, specialists, and hospitals.</p> <p>Referral required for network hospitals and specialists (for certain benefits).</p>
<p>INPATIENT CARE</p> <p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010, the amounts for each benefit period are: Days 1 - 60: \$1,100 deductible Days 61 - 90: \$275 per day Days 91 - 150: \$550 per lifetime reserve day</p> <p>Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days.</p> <p>Lifetime reserve days can only be used once.</p>	<p>In-Network In 2010, the amounts for each benefit period are: Days 1 - 60: \$1,100 deductible Days 61 - 90: \$275 per day Days 91 - 150: \$550 per lifetime reserve day</p> <p>You will not be charged additional cost sharing for professional services.</p>	<p>In-Network For Medicare-covered hospital stays: Days 1 - 7: \$200 co-pay per day Days 8 - 90: \$0 co-pay per day \$0 co-pay for additional hospital days</p> <p>No limit to the number of days covered by the Plan each benefit period.</p> <p>Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>3 - Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>(cont.) A “benefit period” starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>		
<p>4 - Inpatient Mental Health Care</p>	<p>Same deductible and co-pay as inpatient hospital care (see “Inpatient Hospital Care” above). 190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network Same deductible and co-pay as inpatient hospital care (see “Inpatient Hospital Care”). You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital.</p>	<p>In-Network For Medicare-covered hospital stays: Days 1 - 7: \$200 co-pay per day Days 8 - 90: \$0 co-pay per day You get up to 190 days in a Psychiatric Hospital in a lifetime. Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>5 - Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2010, the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$137.50 per day</p> <p>100 days for each benefit period.</p> <p>A “benefit period” starts the day you go into a hospital or SNF. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods you can have.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In 2010, the amounts for each benefit period after at least a 3-day covered hospital stay are:</p> <p>Days 1 - 20: \$0 per day Days 21 - 100: \$137.50 per day</p> <p>You will not be charges additional cost sharing for professional services.</p> <p>Plan covers 100 days for each benefit period.</p> <p>3-day prior hospital stay is required.</p>	<p>General Authorization rules may apply.</p> <p>In-Network For Medicare-covered SNF stays:</p> <p>Days 1 - 20: \$0 co-pay per day Days 21 - 100: \$50 co-pay per day</p> <p>Plan covers up to 100 days each benefit period.</p> <p>3-day prior hospital stay is required</p>
<p>6 - Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 co-pay.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered home health visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered home health visits.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p> <p>You must get care from a Medicare certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>	<p>General You must get care from a Medicare-certified hospice.</p>
<p>OUTPATIENT CARE</p> <p>8 - Doctor Office Visits</p>	<p>20% co-insurance</p>	<p>General See “Physical Exams,” for more information. Authorization rules may apply.</p> <p>In-Network \$0 co-pay for each primary care doctor visit for Medicare-covered benefits.</p> <p>20% of the cost for each specialist visit for Medicare-covered benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$10 co-pay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$25 co-pay for each specialist visit for Medicarecovered benefits.</p>
<p>9 - Chiropractic Services</p>	<p>Routine care not covered.</p> <p>20% co-insurance for manual manipulation of the spine to correct sub luxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for each Medicare covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for each Medicare covered visit.</p> <p>Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part) if you get it from a chiropractor or other qualified providers.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>10 - Podiatry Services</p>	<p>Routine care not covered.</p> <p>20% co-insurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for each Medicare-covered visit.</p> <p>Medicare-covered podiatry benefits are for medically necessary foot care.</p>
<p>11 - Outpatient Mental Health Care</p>	<p>45% co-insurance for most outpatient mental health services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 45% of the cost for each Medicare-covered individual or group therapy visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for each Medicare-covered individual or group therapy visit.</p>
<p>12 - Outpatient Substance Abuse Care</p>	<p>20% co-insurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 45% of the cost for Medicare-covered individual or group visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for Medicare-covered individual or group visits.</p>
<p>13 - Outpatient Services/ Surgery</p>	<p>20% co-insurance for the doctor</p> <p>20% of outpatient facility charges</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for each Medicare-covered ambulatory surgical center visit.</p> <p>20% of the cost for each Medicare-covered outpatient hospital facility visit.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for each Medicare-covered ambulatory surgical center visit.</p> <p>\$0 co-pay for each Medicare-covered outpatient hospital facility visit.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
14 - Ambulance Services (medically necessary ambulance services)	20% co-insurance	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered ambulance benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$50 co-pay for Medicare-covered ambulance benefits.</p> <p>If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.</p>
<p>15 - Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% co-insurance for the doctor</p> <p>20% of facility charge, or a set co-pay per emergency room visit</p> <p>You don't have to pay the emergency room co-pay if you are admitted to the hospital for the same condition within 3 days of the emergency room visit.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General 20% of the cost (up to \$50) for Medicare-covered emergency room visits</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>	<p>General \$50 co-pay for Medicare-covered emergency room visits.</p> <p>\$100,000 limit for emergency services outside the U.S. every year.</p> <p>If you are immediately admitted to the hospital, you pay \$0 for the emergency room visit.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, you pay \$0 for the emergency room visit.</p>
<p>16 - Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% co-insurance, or a set co-pay</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General 20% of the cost for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, \$0 for the urgent-care visit.</p>	<p>General \$50 co-pay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24-hours for the same condition, \$0 for the urgent-care visit.</p>

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<p>17 - Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% co-insurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered Occupational Therapy visits.</p> <p>20% of the cost for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for Medicare-covered Occupational Therapy visits.</p> <p>\$25 co-pay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>
<p>OUTPATIENT MEDICAL SERVICES AND SUPPLIES</p> <p>18 - Durable Medical Equipment (includes wheelchairs, oxygen, etc.)</p>	<p>20% co-insurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
<p>19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)</p>	<p>20% co-insurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered items.</p>
<p>20 - Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)</p>	<p>20% co-insurance</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% to 50% of the cost for Diabetes self-monitoring training.</p> <p>20% of the cost for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>	<p>In-Network \$10 to \$25 co-pay for Diabetes self-monitoring training.</p> <p>\$10 to \$25 co-pay for Nutrition Therapy for Diabetes.</p> <p>20% of the cost for Diabetes supplies.</p>

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BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>21 - Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>20% co-insurance for diagnostic tests and x-rays</p> <p>\$0 co-pay for Medicare-covered lab services</p> <p>Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for Medicare-covered lab services.</p> <p>20% of the cost for Medicare-covered diagnostic procedures and tests.</p> <p>20% of the cost for Medicare-covered X-rays.</p> <p>20% of the cost for Medicare-covered diagnostic radiology services.</p> <p>20% of the cost for Medicare-covered therapeutic radiology services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay for Medicare-covered lab services.</p> <p>\$25 co-pay for Medicare-covered diagnostic procedures and tests.</p> <p>\$100 co-pay for Medicare-covered X-rays.</p> <p>\$100 co-pay for Medicare-covered diagnostic radiology services.</p> <p>\$100 co-pay for Medicare covered therapeutic radiology services.</p> <p>Separate Office Visit cost sharing of \$10 co-pay may apply.</p>
<p>PREVENTIVE SERVICES</p>	<p>20% co-insurance</p>	<p>General Authorization rules may apply.</p>	<p>In-Network</p>
<p>22 - Bone Mass Measurement (for people with Medicare who are at risk)</p>	<p>Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.</p>	<p>In-Network 20% of the cost for Medicare-covered bone mass measurement.</p>	<p>\$10 co-pay for Medicare-covered bone mass measurement.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>23 - Colorectal Screening Exams (for people with Medicare age 50 and older)</p>	<p>20% co-insurance</p> <p>Covered when you are high risk or when you are age 50 and older.</p>	<p>In-Network 0% to 25% of the cost for Medicare-covered colorectal screenings.</p>	<p>In-Network \$10 co-pay for Medicare-covered colorectal screenings.</p>
<p>24 - Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)</p>	<p>\$0 co-pay for Flu and Pneumonia vaccines</p> <p>20% co-insurance for Hepatitis B vaccine</p> <p>You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Flu and Pneumonia vaccines.</p> <p>20% of the cost for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>	<p>In-Network \$0 co-pay for Flu and Pneumonia vaccines.</p> <p>\$0 co-pay for Hepatitis B vaccine.</p> <p>No referral needed for Flu and Pneumonia vaccines.</p>
<p>25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)</p>	<p>20% co-insurance</p> <p>No referral needed.</p> <p>Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with Medicare between age 35 and 39.</p>	<p>In-Network 20% of the cost for Medicare-covered screening mammograms.</p>	<p>In-Network \$10 co-pay for Medicare-covered screening mammograms.</p>
<p>26 - Pap Smears and Pelvic Exams (for women with Medicare)</p>	<p>\$0 co-pay for Pap Smears</p> <p>Covered once every 2 years. Covered once a year for women with Medicare at high risk.</p> <p>20% co-insurance for Pelvic Exams</p>	<p>In-Network 20% of the cost for Medicare-covered Pap Smears and Pelvic Exams.</p>	<p>In-Network \$10 co-pay for Medicare-covered Pap Smears and Pelvic Exams.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)</p>	<p>20% co-insurance for the digital rectal exam.</p> <p>\$0 for the PSA test; 20% co-insurance for other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>In-Network \$0 co-pay for Medicare-covered prostate cancer screening.</p>	<p>In-Network \$10 co-pay for Medicare-covered prostate cancer screening.</p>
<p>28 - End-Stage Renal Disease</p>	<p>20% co-insurance for renal dialysis</p> <p>20% co-insurance for Nutrition Therapy for End-Stage Renal Disease</p> <p>Nutrition therapy is for people who have diabetes or kidney disease (but aren't on dialysis or haven't had a kidney transplant) when referred by a doctor. These services can be given by a registered dietitian or include a nutritional assessment and counseling to help you manage your diabetes or kidney disease.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 20% of the cost for renal dialysis.</p> <p>20% of the cost for Nutrition Therapy for End-Stage Renal Disease.</p>	<p>In-Network 20% of the cost for renal dialysis.</p> <p>\$10 to \$25 co-pay for Nutrition Therapy for End-Stage Renal Disease.</p>
<p>29 - Prescription Drugs</p>	<p>Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B covered drugs.</p>	<p>Drugs covered under Medicare Part B</p> <p>General 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>29 - Prescription Drugs (continued)</p>		<p>Drugs covered under Medicare Part D</p> <p>General This Plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at www.ccmny.org on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/Urban (Indian Health Service). <p>The Plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the Plan’s service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the Plan. The Plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from CCM Direct Complete Plan (HMO) for certain drugs.</p>	<p>Drugs covered under Medicare Part D</p> <p>General This Plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at www.ccmny.org on the web. Different out-of-pocket costs may apply for people who</p> <ul style="list-style-type: none"> - have limited incomes, - live in long term care facilities, or - have access to Indian/Tribal/ Urban (Indian Health Service). <p>The Plan offers national in-network prescription coverage (i.e., this would include 50 states and DC). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the Plan’s service area (for instance when you travel). Total yearly drug costs are the total drug costs paid by both you and the Plan. The Plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.</p> <p>Some drugs have quantity limits. Your provider must get prior authorization from CCM Direct Advantage Plan (HMO) for certain drugs.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>29 - Prescription Drugs (continued)</p>		<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the Plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network \$310 yearly deductible.</p> <p>Initial Coverage You pay the following until total yearly drug costs reach \$2,830.</p> <p>Retail Pharmacy You can get drugs the following ways: <ul style="list-style-type: none"> - one-month (31-day) supply - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the Plan for more information.</p>	<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements for these drugs that cannot be met by most pharmacies in your network. These drugs are listed on the Plan’s website, formulary, and printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov. If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.</p> <p>In-Network \$310 yearly deductible.</p> <p>Initial Coverage After you pay your yearly deductible, you pay 25% until total yearly drug costs reach \$2,830.</p> <p>Retail Pharmacy You can get drugs the following ways: <ul style="list-style-type: none"> - one-month (31-day) supply - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the Plan for more information.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>29 - Prescription Drugs (continued)</p>		<p>Long Term Care Pharmacy You can get drugs the following way: - one-month (31-day) supply</p> <p>Mail Order You can get drugs the following way: - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the Plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$ 4,550, you pay the greater of: - A \$ 2.50 co-pay for generic (including brand drugs treated as generic) and a \$ 6.30 co-pay for all other drugs, or - 5% co-insurance.</p>	<p>Long Term Care Pharmacy You can get drugs the following way: - one-month (31-day) supply</p> <p>Mail Order You can get drugs the following ways: - one-month (31-day) supply - three-month (90-day) supply Not all drugs are available at this extended day supply. Please contact the Plan for more information.</p> <p>Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% until your yearly out-of-pocket drug costs reach \$4,550.</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$ 4,550, you pay the greater of: - A \$ 2.50 co-pay for generic (including brand drugs treated as generic) and a \$ 6.30 co-pay for all other drugs, or - 5% co-insurance.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>29 - Prescription Drugs (continued)</p>		<p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the Plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from CCM Direct Complete Plan (HMO).</p> <p>You can get drugs the following way: - one-month (31-day) supply</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach \$2,830.</p>	<p>Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the Plan’s service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy’s full charge for the drug and submit documentation to receive reimbursement from CCM Direct Advantage Plan (HMO).</p> <p>You can get drugs the following way: - one-month (31-day) supply</p> <p>Out-of-Network Initial Coverage After you pay your yearly deductible, you will be reimbursed up to 75% of the actual cost for drugs purchased out-of-network until your total yearly drug costs reach \$2,830.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>29 - Prescription Drugs (continued)</p>		<p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by CCM Direct Complete Plan (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to CCM Direct Complete Plan (HMO) so we can add the amounts you spent out-of-network to your total out-of pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> - A \$ 2.50 co-pay for generic (including brand drugs treated as generic) and a \$ 6.30 co-pay for all other drugs, or - 5% co-insurance. </p>	<p>Out-of-Network Coverage Gap After your total yearly drug costs reach \$2,830, you pay 100% of the pharmacy’s full charge for drugs purchased out-of-network until your yearly out-of-pocket drug costs reach \$4,550. You will not be reimbursed by CCM Direct Advantage Plan (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to CCM Direct Advantage Plan (HMO) so we can add the amounts you spent out-of-network to your total out-of pocket costs for the year.</p> <p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$ 4,550, you will be reimbursed for drugs purchased out-of-network up to the full cost of the drug minus the following: <ul style="list-style-type: none"> - A \$ 2.50 co-pay for generic (including brand drugs treated as generic) and a \$ 6.30 co-pay for all other drugs, or - 5% co-insurance. </p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network In general, preventive dental benefits (such as cleaning) not covered.</p> <p>20% of the cost for Medicare-covered dental benefits.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for Medicare-covered dental benefits.</p> <p>\$0 co-pay for the following preventive dental benefits: - up to 1 oral exam every six months - up to 1 cleaning every six months - up to 1 dental x-ray</p> <p>Plan offers additional comprehensive dental benefits.</p>
31 - Hearing Services	<p>Routine hearing exams and hearing aids not covered.</p> <p>20% co-insurance for diagnostic hearing exams.</p>	<p>General Authorization rules may apply.</p> <p>In-Network In general, routine hearing exams and hearing aids not covered.</p> <p>20% of the cost for Medicare-covered diagnostic hearing exams.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for up to 1 hearing aid every three years.</p> <p>\$25 co-pay for Medicare-covered diagnostic hearing exams.</p> <p>\$25 co-pay for up to 1 routine hearing test every year.</p> <p>\$1,000 limit for hearing aids every three years.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
<p>32 - Vision Services</p>	<p>20% co-insurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eye glasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>\$0 co-pay for diagnosis and treatment for diseases and conditions of the eye.</p> <p>\$0 co-pay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair of glasses every two years - up to 1 pair of contacts every two years - up to 1 pair of lenses every two years - up to 1 frame every two years <p>\$100 limit for eye wear every two years.</p>	<p>In-Network</p> <p>\$0 co-pay for diagnosis and treatment for diseases and conditions of the eye.</p> <ul style="list-style-type: none"> - and up to 1 routine eye exam(s) every year <p>\$0 co-pay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery - up to 1 pair of glasses every two years - up to 1 pair of contacts every two years - up to 1 pair of lenses every two years - up to 1 frame every two years <p>\$100 limit for eye wear every two years.</p>
<p>33 - Physical Exams</p>	<p>20% co-insurance for one exam within the first 12 months of your new Medicare Part B coverage</p> <p>When you get Medicare Part B, you can get a one time physical exam within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p>	<p>In-Network</p> <p>When you get Medicare Part B, you can get a one-time physical within the first 12 months of your new Part B coverage. The coverage does not include lab tests.</p> <p>Routine exams not covered.</p>	<p>In-Network</p> <p>\$10 co-pay for routine exams.</p> <p>Limited to 1 exam every year.</p> <p>\$10 co-pay for Medicare-covered benefits.</p>

SUMMARY OF BENEFITS

BENEFIT CATEGORY	ORIGINAL MEDICARE	CCM DIRECT COMPLETE (HMO)	CCM DIRECT ADVANTAGE (HMO)
Health/Wellness Education	<p>Smoking Cessation: Covered if ordered by your doctor.</p> <p>Includes two counseling attempts within a 12-month period if you are diagnosed with a smoking-related illness or are taking medicine that may be affected by tobacco. Each counseling attempt includes up to four face-to-face visits. You pay coinsurance, and Part B deductible applies.</p>	<p>General Please visit our Plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the Plan for specific instructions for using this benefit.</p> <p>In-Network The Plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training <p>\$0 co-pay for each Medicare-covered smoking cessation counseling session</p>	<p>General Please visit our Plan website to see our list of covered Over-the-Counter items. OTC items may be purchased only for the enrollee. Please contact the Plan for specific instructions for using this benefit.</p> <p>In-Network The Plan covers the following health/wellness education benefits:</p> <ul style="list-style-type: none"> - Written health education materials, including Newsletters - Nutritional Training <p>\$0 co-pay for each Medicare-covered smoking cessation counseling session</p>
Transportation (Routine)	<p>Not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay for each round trip to Plan-approved location.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 9 round trips to Plan approved location every year.</p>
Acupuncture	<p>Not covered.</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$0 co-pay</p>	<p>General Authorization rules may apply.</p> <p>In-Network \$25 co-pay per visit.</p>

Summary of Benefits

CCM Direct Complete Plan and CCM Direct Advantage Plan are Special Needs Plans for Medicare beneficiaries who require a nursing home level of care either in a nursing home, assisted living facility or in the community.

For Nursing Home Residents

CCM Direct Complete Plan and CCM Direct Advantage Plan will provide you with a Nurse Practitioner in the Nursing Home. The Nurse Practitioner will work as part of the nursing home team visiting you in the nursing home in addition to your physician. These additional visits will assist the nursing home to identify any changes in condition as soon as they occur and assist the nursing home staff in treating the residents in the nursing home whenever possible.

Our Nurse Practitioners also contact family members on a regular basis, so families are always aware of how their loved ones are doing. In addition, the Nurse Practitioners are available to explain the care plan and answer any questions about the member's illness if there is a concern or change in condition.

For Community Residents

CCM Direct Complete Plan and CCM Direct Advantage Plan will provide you a Care Manager who will assist in coordinating your care. When you enroll, CCM's Care Manager will do a complete health history. This will identify medical problems as well as issues you may have managing your care. The Care Manager working with you will develop a plan of care setting goals to deal with health concerns. The Care Manager will help coordinate care between all your providers as well as from community services and will act as an advocate in the health care system.

For CCM Complete members

CCM members receiving assistance from Medicaid will not be responsible for the deductible, co-payments and co-insurance amounts listed in the benefits section. They will be covered by Medicaid. All your care providers except your Primary Care Physician will have to bill Medicaid.

Primary Care Physician

When you join one of the CCM Direct Plans, you select a Primary Care Physician (PCP) in your area from our participating provider directory. Your PCP will provide all preventive services and help to coordinate your overall health care.

Seeing a Specialist

If you need to see a specialist, you do not need a referral from your Primary Care Physician (PCP) to see a participating CCM Specialist. It is important to remember your PCP can assist you in finding a Specialist for your condition, and will ensure you receive appropriate medical care.

Member Services

If you have questions, please call our Member Services Department at 1-877-226-8500, (TTY/TDD 1-800-650-2774), seven days a week from 8:00 am to 8:00 EST

Benefit Highlights of the CCM Direct Medicare Plans

▶ Complete Plan

\$0 Plan Premium if you have Medicaid
Prescription Drug Coverage Benefits

- ▶ \$0 co-pay for primary care physician visits
- ▶ \$100 every 2 years for eyewear
- ▶ \$400/year for non-prescription drugs and health supplies distributed monthly
- ▶ \$50 per quarter for specialized DME
- ▶ \$0 for in network acupuncture services

▶ Advantage Plan

Prescription Drug Coverage Benefits

- ▶ \$10 co-pay for primary care physician visits
- ▶ \$25 co-pay for specialist visits
- ▶ \$3,400 out of pocket maximum cost for medical services
- ▶ \$0 for dental exams and cleanings plus comprehensive dental benefits
- ▶ Up to \$1,000 for hearing aids every 3 years
- ▶ \$100 every 2 years for eyewear
- ▶ \$240/year for non-prescription drugs and health supplies distributed monthly
- ▶ Worldwide coverage for Emergency Care up to \$100,000 per year



For questions on CCM Direct Medicare Plans, please call our Member Services Department at:

**1-877-226-8500
1-800-650-2774 (TTY/TDD)**

Calls to these numbers are free.
Sunday, Monday, Tuesday, Wednesday,
Thursday, Friday, Saturday
8:00 am to 8:00 EST