



Summary of Benefits

CCM Direct – Total (HMO)

H5989 Comprehensive Care Management Corporation

January 1, 2010- December 31, 2010

Welcome to CCM Direct

January 1, 2010 - December 31, 2010

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).

8:00 am to 8:00 pm Eastern, 7 days a week

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Section I – Introduction to Summary of Benefits

Thank you for your interest in CCM Direct Total (HMO). This plan is offered by Comprehensive Care Management Corporation, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan. These plans are designed for people who meet specific enrollment criteria.

If you require a nursing home level of care you may be eligible to join this plan. Please call CCM Direct Total (HMO) to find out if you are eligible to join. Our number is listed at the end of this introduction.

The Summary of Benefits tells you some features of our plan. 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 Total (HMO) and ask for the "Evidence of Coverage".

You have choices in your healthcare.

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 Total (HMO) Plan. 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 Total (HMO) at the telephone number listed at the end of this introduction, or 1-800-MEDICARE (1-800-633-4227) for more information. TTY 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 Total (HMO) Plan and 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 plans cover 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 is CCM Direct Total (HMO) available?

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

Who is Eligible to join CCM Direct Total (HMO)?

You can join CCM Direct Total (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 (ESRD) are generally not eligible to enroll in CCM Direct Total (HMO) unless they are member of our organization and have been since their dialysis began.

Special Eligibility Requirements for this Plan

CCM Direct Total (HMO) has been designed to meet the needs of people who live in a nursing home or are otherwise eligible for nursing home level of care. If you have questions about your eligibility, please contact our Member Services Department.

Can I choose my doctors?

CCM Direct Total (HMO) has 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 for an up-to-date list or 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 the CCM Direct Total (HMO) or the Original Medicare Plan will pay for these services.

Does my plan cover Medicare Part B or Part D drugs?

CCM Direct Total (HMO) does 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 Total (HMO) has 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 Network List 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 Total (HMO) uses a formulary. A formulary is a list of drugs covered by your plan to meet patient needs. We may periodically add, remove, 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 members 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 requirement 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 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 users should call 1-877-486-2048. You can call this number 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/TTD 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 60 days before your coverage will end. The letter will explain your options for Medicare coverage in your area.

As a member of CCM Direct Total (HMO) you have the right to request an organization determination which includes 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 Total (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. 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.

What is a Medication Therapy Management (MTM) program?

A Medication Therapy Management (MTM) Program is a free service that 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 Total (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 Total Plan for more details.

- ◆ Some Antigenes: 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 alpha 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 Total Plan

Visit us at www.ccmny.org or call us:

Member Services

8:00 AM to 8:00 PM EST, 7 days a week

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.

Comprehensive Care Management (CCM)
2401 White Plains Road
Bronx, NY 10467

CCM Direct Total (HMO) 2010

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

Benefit	Original Medicare	CCM Direct Total (HMO) - Medicare
1 - Premium and Other Important Information	<p>Most Medicare beneficiaries will continue to pay the same \$96.40 Part B premium amount in 2010 and the yearly Part B 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>2 - Doctor and Hospital Choice</p> <p>(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>3 - Inpatient Hospital Care</p> <p>(includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2010, the amounts for each benefit period are:</p> <p>Days 1 - 60: \$1,100 deductible</p> <p>Days 61 - 90: \$275 per day</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays: Days 1-7: \$175 copay per day</p>

	<p>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>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>Days 8-90: \$0 copay per day \$0 copay 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>
4 - Inpatient Mental Health Care	<p>Same deductible and copay as inpatient hospital care (see "Inpatient Hospital Care" above).</p> <p>190 day lifetime limit in a Psychiatric Hospital.</p>	<p>In-Network</p> <p>For Medicare-covered hospital stays: Days 1-7: \$175 copay per day Days 8-90: \$0 copay per day \$0 copay for additional hospital days.</p> <p>You get up to 190 days in a Psychiatric Hospital in a lifetime.</p> <p>Except in an emergency, your doctor must tell the Plan that you are going to be admitted to the hospital.</p>
5 - Skilled Nursing Facility (SNF)	In 2010, the amounts for each benefit	General

<p>(in a Medicare-certified skilled nursing facility)</p>	<p>period after at least a 3-day covered hospital stay are: 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>Authorization rules may apply.</p> <p>In-network For Medicare-covered SNF stays: Days 1-20: \$0 copay per day Days 21-100: \$125 copay per day.</p> <p>Plan covers up to 100 days per benefit period. 3-day prior hospital stay is required.</p>
<p>6 - Home Health Care</p> <p>(includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)</p>	<p>\$0 copay.</p>	<p>General Authorization rules may apply.</p> <p>In-network \$0 copay for Medicare-covered home health visits.</p>
<p>7 - Hospice</p>	<p>You pay part of the cost for outpatient drugs and inpatient respite care.</p>	<p>General You must get care from a Medicare-certified hospice.</p>

	You must get care from a Medicare-certified hospice.	
8 - Doctor Office Visits	20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-network \$10 copay for each primary care doctor visit for Medicare-covered benefits.</p> <p>\$50 copay for each specialist visit of Medicare-covered benefits.</p>
9 - Chiropractic Services	<p>Routine care not covered</p> <p>20% coinsurance 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 \$50 copay 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>
10 - Podiatry Services	<p>Routine care not covered.</p> <p>20% coinsurance 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 \$50 copay for each Medicare-covered visit.</p>

		Medicare-covered podiatry benefits are for medically necessary foot care.
11 - Outpatient Mental Health Care	45% coinsurance for most outpatient mental health services.	General Authorization rules may apply. In-network \$50 copay for each Medicare-covered individual or group therapy visit.
12 - Outpatient Substance Abuse Care	20% coinsurance	General Authorization rules may apply. In-network \$50 copay for each Medicare-covered individual or group therapy visit.
13 - Outpatient Services/Surgery	20% coinsurance for the doctor. 20% of outpatient facility charges.	General Authorization rules may apply. In-network \$200 copay for each Medicare-covered ambulatory surgical center visit. \$200 copay for each Medicare-covered outpatient hospital facility visit.
14 - Ambulance Services (medically necessary ambulance services)	20% coinsurance	In-Network \$50 copay for Medicare-covered ambulance benefits. If you are admitted to the hospital, you pay \$0 for Medicare-covered ambulance benefits.

<p>15 - Emergency Care</p> <p>(You may go to any emergency room if you reasonably believe you need emergency care.)</p>	<p>20% coinsurance for the doctor.</p> <p>20% of facility charge, or a set copay per emergency room visit.</p> <p>You don't have to pay the emergency room copay 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</p> <p>\$50 copay 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 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</p> <p>(This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>20% coinsurance, or a set copay.</p> <p>NOT covered outside the U.S. except under limited circumstances.</p>	<p>General</p> <p>\$10 copay for Medicare-covered urgently needed care visits.</p> <p>If you are admitted to the hospital within 24 hours for the same condition, \$0 copay for the urgent-care visit.</p>
<p>17 - Outpatient Rehabilitation Services</p> <p>(Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>20% coinsurance</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>\$50 copay for Medicare-covered Occupational Therapy visit.</p> <p>\$50 copay for Medicare-covered Physical and/or Speech/Language Therapy visits.</p>
<p>18 - Durable Medical Equipment</p>	<p>20% coinsurance</p>	<p>General</p> <p>Authorization rules may apply.</p>

(includes wheelchairs, oxygen, etc.)		In-Network \$0 copay for Medicare-covered items.
19 - Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	20% coinsurance	General Authorization rules may apply. In-Network \$0 copay for Medicare-covered items.
20 - Diabetes Self- Monitoring Training, Nutrition Therapy, and Supplies (includes coverage for glucose monitors, test strips, lancets, screening tests, and self-management training)	20% coinsurance 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.	In-Network \$0 copay for Diabetes self-monitoring training. \$0 copay for Nutrition Therapy for Diabetes. \$0 copay for Diabetes supplies.
21 - Diagnostic Tests, X- Rays, and Lab Services	20% coinsurance for diagnostic tests and x-rays. \$0 copay for Medicare-covered lab services. 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	General Authorization rules may apply. In-Network \$0 copay for Medicare- covered: - lab services - diagnostic procedures and tests - X-rays. - Diagnostic radiology services (not including X-rays) - Therapeutic radiology services

	doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most routine screening tests, like checking your cholesterol.	Separate Office Visit cost sharing of \$10 may apply.
22 - Bone Mass Measurement (for people with Medicare who are at risk)	20% coinsurance Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions.	In-Network \$0 copay for Medicare-covered bone mass measurement. Separate Office Visit cost sharing of \$10 may apply.
23 - Colorectal Screening Exams (for people with Medicare age 50 and older)	20% coinsurance Covered when you are high risk or when you are age 50 and older.	In-Network \$0 copay for Medicare-covered colorectal screenings. Separate Office Visit cost sharing of \$10 may apply.
24 – Immunizations (Flu vaccine, Hepatitis B vaccine - for people with Medicare who are at risk, Pneumonia vaccine)	\$0 copay for Flu and Pneumonia vaccines. 20% coinsurance for Hepatitis B vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information.	In-Network \$0 copay for Flu and Pneumonia vaccines. \$0 copay for Hepatitis B vaccine. No referral needed for Flu and Pneumonia vaccines.
25 - Mammograms (Annual Screening) (for women with Medicare age 40 and older)	20% coinsurance No referral needed. Covered once a year for all women with Medicare age 40 and older. One baseline mammogram covered for women with	In-Network \$0 copay for Medicare-covered screening mammograms. Separate Office Visit cost sharing of \$10 may apply.

	Medicare between age 35 and 39.	
26 - Pap Smears and Pelvic Exams (for women with Medicare)	\$0 copay for Pap smears Covered once every 2 years. Covered once a year for women with Medicare at high risk. 20% coinsurance for Pelvic Exams.	In-Network \$0 copay for Medicare-covered Pap smears and Pelvic Exams. Separate Office Visit cost sharing of \$10 may apply.
27 - Prostate Cancer Screening Exams (for men with Medicare age 50 and older)	20% coinsurance for the digital rectal exam. \$0 for the PSA test; 20% coinsurance for other related services. Covered once a year for all men with Medicare over age 50.	In-Network \$0 copay for Medicare-covered prostate cancer screening. Separate Office Visit cost sharing of \$10 may apply.
28 - End-Stage Renal Disease	20% coinsurance for renal dialysis. 20% coinsurance for Nutrition Therapy for End- Stage Renal Disease. 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.	In-Network 20% of the cost for renal dialysis. \$0 copay for Nutrition Therapy for End-Stage Renal Disease.
29 - Prescription Drugs	Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining	Drugs covered under Medicare Part B General 20% of the cost for Part B-covered chemotherapy drugs and other Part

	<p>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>B-covered drugs.</p>
		<p>Drugs covered under Medicare Part D General This Plan uses a formulary. The Plan will send you the formulary. You can also see the formulary at http://www.ccmny.org on the web.</p>
		<p>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).</p> <p>Total yearly drug costs are the total drug costs paid by both you and the Plan.</p>

		<p>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.</p> <p>Your provider must get prior authorization from CCM Direct Total (HMO) for certain drugs.</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.</p> <p>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</p>
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		<p>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 way(s): -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>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</p> <p>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</p>
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		<p>After your yearly out-of-pocket drug costs reach \$ 4,350, you pay the greater of:</p> <ul style="list-style-type: none"> - \$2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs or - 5% coinsurance. <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 Total (HMO).</p> <p>You can get drugs the following way:</p> <ul style="list-style-type: none"> -one-month (31-day) supply. <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>
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		<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 Total (HMO) for out-of-network purchases when you are in the coverage gap. However, you should still submit documentation to CCM Direct Total (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:</p> <ul style="list-style-type: none"> - A \$ 2.50 copay for generic (including brand drugs treated as generic) and a \$6.30 copay for all other drugs or - 5% coinsurance
30 - Dental Services	Preventive dental services (such as cleaning) not covered.	In-Network \$0 copay for Medicare-covered dental benefits

		In general, preventive dental services (such as cleaning) not covered.
31 - Hearing Services	Routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	In-Network In general, routine hearing exams and hearing aids not covered \$0 copay for Medicare-covered diagnostic hearing exams.
32 - Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye. Routine eye exams and glasses not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery. Annual glaucoma screenings covered for people at risk.	In-Network \$0 copay for diagnosis and treatment for diseases and conditions of the eye. Up to one routine refraction exam every 2 years unless medically necessary. \$0 copay for one pair of eyeglasses or contact lenses after cataract surgery.
33 - Physical Exams	20% coinsurance for one exam within the first 12 months of your new Medicare Part B coverage. 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.	In-Network 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. Routine exams not covered.
Health/Wellness Education	Smoking Cessation: Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period if you are	General Please visit our Plan website to see our list of Over-the-Counter items.

	<p>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>OTC items may be purchased only for the enrollee.</p> <p>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 - \$0 copay for each Medicare-covered smoking cessation counseling session.
Transportation	Not covered	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for each round trip to Plan-approved location.</p>
Acupuncture	Not covered	<p>General Authorization rules may apply.</p> <p>In network \$0 copay</p>

CCM Direct Total (HMO) is a 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 Community Residents

CCM Direct Total (HMO) Plan will provide you a Care Manager who will assist in coordinating your care. When you enroll, CCM's Direct Total (HMO) plan a 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 Members who have full Medicaid and enroll in the NYS Medicaid Advantage Plus (MAP) Program

Members enrolled in CCM Direct Total (HMO) are eligible to enroll in the CCM Medicaid Advantage Plus (MAP) program. CCM members enrolled in MAP will not be responsible for the deductible, co-payments and coinsurance amounts listed in the benefits section with the exception of Chiropractic and copays for prescription drugs. MAP enrollees will also be eligible for home care services and other benefits covered under MAP and these benefits will be coordinated with your CCM Direct Total (HMO) benefits. Members will be covered by Medicaid for all services covered by NYS under the MAP program. Please see the CCM Direct Total (HMO) Medicaid Advantage Plus Member Handbook for details concerning the combined coverage

For Nursing Home Residents

CCM Direct Total (HMO) 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.

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).

Benefit Highlights of the CCM Direct Total (HMO) Plan

\$0 Plan Premium if you have Medicaid

Prescription Drug Coverage

Up to \$100 every 2 years for eyewear

Up to \$115/year (\$12.55/month) for non-prescription drugs and health supplies

\$0 for in network acupuncture services

\$0 copay for each round trip to plan-approved location

Worldwide emergency coverage up to \$100,000 per year

If you have Medicaid, you will continue to be covered for dental service, hearing aids and diabetic supplies. Medicaid will continue to cover copayments for Medicaid covered services.