

SUMMARY OF
BENEFITS
2012

Elderplan For Medicaid Beneficiaries (HMO SNP)

January 1, 2012 to December 31, 2012

Elderplan Summary of Benefits

for Elderplan For Medicaid Beneficiaries (HMO SNP)

January 1, 2012–December 31, 2012

NEW YORK CITY METROPOLITAN AREA

Elderplan has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 12/31/2013. NCQA's approval is based on a review of Elderplan Model of Care and is an indicator of compliance with CMS requirements. NCQA's approval is not an endorsement by CMS and/or NCQA of Elderplan or the quality of service provided by Elderplan. Elderplan will still need to be approved each year by CMS in order to operate. If you have questions regarding our approval by the NCQA, please contact us at 1-800-353-3765.

Proposed Effective Date _____ / _____ / _____

Primary Care Provider

Name _____

Address _____

Phone Number (_____) _____

Name of Sales Representative _____

Important Numbers

Member Services: 1-800-353-3765

TTY: 1-800-662-1220 8 a.m. to 8 p.m., 7 days a week

Section I: Introduction to the Summary of Benefits

Thank you for your interest in Elderplan For Medicaid Beneficiaries (HMO SNP)

Our plan is offered by ELDERPLAN, INC./Elderplan, a Medicare Advantage Health Maintenance Organization (HMO) Special Needs Plan (SNP). This plan is designed for people who meet specific enrollment criteria. You may be eligible to join this plan if you receive assistance from the state and Medicare.

All cost sharing in this summary of benefits is based on your level of Medicaid eligibility.

Please call Elderplan For Medicaid Beneficiaries (HMO SNP) 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 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 Elderplan For Medicaid Beneficiaries (HMO SNP) 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 Elderplan For Medicaid Beneficiaries (HMO SNP). 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 eligible for both Medicare and Medicaid (dual eligible) you may join or leave a plan at any time.

Please call Elderplan For Medicaid Beneficiaries (HMO SNP) 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 Elderplan For Medicaid Beneficiaries (HMO SNP) 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 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 Is Elderplan For Medicaid Beneficiaries (HMO SNP) Available?

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

Who Is Eligible To Join Elderplan For Medicaid Beneficiaries (HMO SNP)?

You can join Elderplan For Medicaid Beneficiaries (HMO SNP) 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 Elderplan For Medicaid Beneficiaries (HMO SNP) unless they are members of our organization and have been since their dialysis began. You must also receive assistance from the state to join this plan. Please call the plan to see if you are eligible to join.

Can I Choose My Doctors?

Elderplan For Medicaid Beneficiaries (HMO SNP) 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 updated list, visit us at www.elderplan.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 except in limited situations (for example, emergency care). Neither the plan nor the Original Medicare Plan will pay for these services.

Where Can I Get My Prescriptions If I Join This Plan?

Elderplan For Medicaid Beneficiaries (HMO SNP) 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 directory or visit us at www.envisionrx.com. Our customer service number is listed at the end of this introduction.

Does My Plan Cover Medicare Part B Or Part D Drugs?

Elderplan For Medicaid Beneficiaries (HMO SNP) does cover both Medicare Part B prescription drugs and Medicare Part D prescription drugs.

What Is A Prescription Drug Formulary?

Elderplan For Medicaid Beneficiaries (HMO SNP) uses 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 affected 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.elderplan.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 or Get Extra Help With Other Medicare Costs?

You may be able to get extra help to pay for your prescription drug premiums and costs as well as get help with other Medicare 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 and see **www.medicare.gov** 'Programs for People with Limited Income and Resources' in the publication Medicare You.
- 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 calendar year at a time. Plan benefits and cost-sharing may change from calendar year to calendar year. Each year, plans can decide whether to continue to participate with Medicare Advantage. A plan may continue in their entire service area (geographic area where the plan accepts members) or choose to continue only in certain areas. Also, Medicare may decide to end a contract with a plan. Even if your Medicare Advantage Plan leaves the program, you will not lose Medicare coverage. If a plan decides not to continue

for an additional calendar year, 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 Elderplan For Medicaid Beneficiaries (HMO SNP), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information. As a member of Elderplan For Medicaid Beneficiaries (HMO SNP), 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. Please refer to the Evidence of Coverage (EOC) for the QIO contact information.

What Is A Medication Therapy Management (MTM) Program?

A Medication Therapy Management (MTM) Program is a free service we 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 Elderplan For Medicaid Beneficiaries (HMO SNP) 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 Elderplan For Medicaid Beneficiaries (HMO SNP) 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 administered through DME.

Where Can I Find Information on 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 "Health and Drug Plans" then "Compare Drug and Health Plans" to compare the plan ratings for Medicare plans in your area. You can also call us directly to obtain a copy of the plan ratings for this plan.

Our customer service number is listed below.

Please call Elderplan for more information about Elderplan For Medicaid Beneficiaries (HMO SNP).

Visit us at **www.elderplan.org** or, call us: Customer Service Hours:

Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free 1-800-353-3765 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-662-1220)

Prospective members should call toll-free (866)-695-8101 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-662-1220)

Current members should call locally (718)-921-7979 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-662-1220)

Prospective members should call locally (866)-695-8101 for questions related to the Medicare Advantage Program. (TTY/TDD 1-800-662-1220)

Current members should call toll-free 1-800-353-3765 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-662-1220)

Prospective members should call toll-free 1-866-695-8101 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-662-1220) Current members should call locally (718)-921-7979 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-662-1220)

Prospective members should call locally 1-866-695-8101 for questions related to the Medicare Part D Prescription Drug program. (TTY/TDD 1-800-662-1220)

For more information about Medicare, please call Medicare at 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.

This document may be available in other formats such as Braille, large print or other alternate formats.

This document may be available in a non-English language. For additional information, call customer service at the phone number listed above.

Este documento podría estar disponible en otro idioma que no sea inglés.

Para más información, llame al servicio al cliente al número de teléfono indicado anteriormente.

If you have any questions about this plan's benefits or costs, please contact Elderplan for details.

Section II: Summary of Benefits

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
IMPORTANT INFORMATION		
<p>1. Premium and Other Important Information</p>	<p>The Medicare cost sharing amount may vary based on your level of Medicaid eligibility.</p> <p>In 2011 the monthly Part B Premium was \$0 or \$96.40 and may change for 2012 and the annual Part B deductible amount was \$0 or \$162 and may change for 2012.*</p> <p>If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more.</p>	<p>General</p> <p>* Depending on your level of Medicaid eligibility, you may not have any cost-sharing responsibility for original Medicare services</p> <p>** Please consult with your plan about cost sharing when receiving services from out-of-network providers.</p> <p>\$36.40 monthly plan premium in addition to your monthly Medicare Part B premium.*</p> <p>In-Network</p> <p>In 2011 the annual Part B deductible amount was \$162 and may change for 2012.</p> <p>Contact the plan for services that apply.</p> <p>\$3,400 out-of-pocket limit for Medicare-covered services.*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
IMPORTANT INFORMATION		
<p>2 . Doctor and Hospital Choice (For more information, see Emergency Care-#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. No referral required for network doctors, specialists, and hospitals.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
INPATIENT CARE		
<p>3. Inpatient Hospital Care (includes Substance Abuse and Rehabilitation Services)</p>	<p>In 2011 the amounts for each benefit period were \$0 or:</p> <p>Days 1—60: \$1132 deductible*</p> <p>Days 61—90: \$283 per day*</p> <p>Days 91—150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</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>In-Network</p> <p>Plan covers 90 days each benefit period.</p> <p>In 2011 the amounts for each benefit period were:</p> <p>Days 1—60: \$1132 deductible*</p> <p>Days 61—90: \$283 per day*</p> <p>Days 91—150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</p> <p>You will not be charged additional cost sharing for professional services.</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
INPATIENT CARE		
<p>4. Inpatient Mental Health Care</p>	<p>In 2011 the amounts for each benefit period were \$0 or:</p> <p>Days 1—60: \$1132 deductible*</p> <p>Days 61—90: \$283 per day*</p> <p>Days 91—150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days if inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital.</p>	<p>In-Network</p> <p>In 2011 the amounts for each benefit period were:</p> <p>Days 1—60: \$1132 deductible*</p> <p>Days 61—90: \$283 per day*</p> <p>Days 91—150: \$566 per lifetime reserve day*</p> <p>These amounts may change for 2012.</p> <p>You get up to 190 days of inpatient psychiatric hospital care in a lifetime. Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. Same deductible and copay as inpatient hospital care (see “Inpatient Hospital Care”)</p> <p>Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
INPATIENT CARE		
<p>5. Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)</p>	<p>In 2011 the amounts for each benefit period after at least a 3-day covered hospital stay were: Days 1—20: \$0 per day* Days 21—100: \$0 or \$141.50 per day* These amounts may change for 2012. 100 days for each benefit period. 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 Plan covers up to 100 days each benefit period No prior hospital stay is required. In 2011 the amounts for each benefit period were: Days 1—20: \$0 per day* Days 21—100: \$141.50 per day* These amounts may change for 2012. You will not be charged additional cost sharing for professional services.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
INPATIENT CARE		
6. Home Health Care (includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	\$0 copay.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for Medicare-covered home health visits*</p>
7. Hospice	<p>You pay part of the cost for outpatient drugs and you may pay part of the cost for 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. Your plan will pay for a consultative visit before you select hospice.</p>
OUTPATIENT CARE		
8. Doctor Office Visits	0% or 20% coinsurance	<p>In-Network 0% or 20% of the cost for each primary care doctor visit for Medicare-covered benefits.*</p> <p>0% or 20% of the cost for each in-area, network urgent care Medicare-covered visit*</p> <p>0% or 20% of the cost for each specialist visit for Medicare-covered benefits.*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT CARE		
9. Chiropractic Services	<p>Supplemental routine care not covered</p> <p>0% or 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</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 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>
10. Podiatry Services	<p>Supplemental routine care not covered.</p> <p>0% or 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.</p>	<p>In-Network</p> <p>0% or 20% of the cost for each Medicare-covered visit*</p> <p>Medicare-covered podiatry benefits are for medically-necessary foot care.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT CARE		
<p>11. Outpatient Mental Health Care</p>	<p>0% or 40% coinsurance for most outpatient mental health services 0% or 40% coinsurance of the Medicare-approved amount for each service you get from a qualified professional as part of a Partial Hospitalization Program.</p> <p>"Partial hospitalization program" is a structured program of active outpatient psychiatric treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 45% of the cost for each Medicare-covered individual therapy visit 0% or 45% of the cost for each Medicare-covered group therapy visit 0% or 20% of the cost for each Medicare-covered individual therapy visit with a psychiatrist* 0% or 20% of the cost for each Medicare-covered group therapy visit with a psychiatrist* 0% or 20% of the cost for Medicare-covered partial hospitalization program services*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT CARE		
12. Outpatient Substance Abuse Care	0% or 20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 45% of the cost for Medicare-covered individual therapy visits* 0% or 45% of the cost for Medicare-covered group therapy visits*</p>
13. Outpatient Services/ Surgery	<p>0% or 20% coinsurance for the doctor's services. Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 0% or 20% coinsurance for ambulatory surgical center facility services.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for each Medicare-covered ambulatory surgical center visit* 0% or 20% of the cost for each Medicare-covered outpatient hospital facility visit*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT CARE		
<p>14. Ambulance Services (medically necessary ambulance services)</p>	<p>0% or 20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost 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>0% or 20% coinsurance for the doctor's services</p> <p>Specified copayment for outpatient hospital facility emergency services.</p> <p>Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital.</p> <p>You don't have to pay the emergency room copay if you are admitted to the hospital as an inpatient 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 0% or 20% of the cost (up to \$65) for Medicare-covered emergency room visits*</p> <p>\$50,000 plan coverage limit for emergency services outside the U.S. every year.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT CARE		
<p>16. Urgently Needed Care (This is NOT emergency care, and in most cases, is out of the service area.)</p>	<p>0% or 20% coinsurance NOT covered outside the U.S. except under limited circumstances.</p>	<p>General 0% or 20% of the cost for Medicare-covered urgently-needed-care visits*</p>
<p>17. Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)</p>	<p>0% or 20% coinsurance</p>	<p>General Authorization rules may apply.</p> <p>In-Network There may be limits on physical therapy, occupational therapy, and speech and language pathology services. If so, there may be exceptions to these limits.</p> <p>0% or 20% of the cost for Medicare-covered Occupational Therapy visits*</p> <p>0% or 20% of the cost for Medicare-covered Physical and/or Speech and Language Therapy visits*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
18. Durable Medical Equipment (includes wheelchairs, oxygen, etc.)	0% or 20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for Medicare-covered items*</p>
19. Prosthetic Devices (includes braces, artificial limbs and eyes, etc.)	0% or 20% coinsurance	<p>General Authorization rules may apply.</p> <p>In-Network 0% or 20% of the cost for Medicare-covered items*</p>
20. Diabetes Programs and Supplies	0% or 20% coinsurance for diabetes self-management training 0% or 20% coinsurance for diabetes supplies 0% or 20% coinsurance for diabetic therapeutic shoes or inserts	<p>In-Network \$0 copay for Diabetes self-management training* 0% or 20% of the cost for Diabetes monitoring supplies* 0% or 20% of the cost for Therapeutic shoes or inserts*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
<p>21. Diagnostic Tests, X-Rays, Lab Services, and Radiology Services</p>	<p>0% or 20% coinsurance for diagnostic tests and x-rays \$0 copay 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 supplemental routine screening tests, like checking your cholesterol.</p> <p>0% or 20% coinsurance for the digital rectal exam and other related services.</p> <p>Covered once a year for all men with Medicare over age 50.</p>	<p>General Authorization rules may apply.</p> <p>In-Network 0% of the cost for Medicare-covered lab services* 0% or 0% to 20% of the cost for Medicare-covered diagnostic procedures and tests* 0% or 20% of the cost for Medicare-covered X-rays* 0% or 20% of the cost for Medicare-covered diagnostic radiology services (not including X-rays)* 0% or 20% of the cost for Medicare-covered therapeutic radiology services*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
OUTPATIENT MEDICAL SERVICES AND SUPPLIES		
22. Cardiac and Pulmonary Rehabilitation Services	<p>0% or 20% coinsurance for Cardiac Rehabilitation services</p> <p>0% or 20% coinsurance for Pulmonary Rehabilitation services</p> <p>0% or 20% coinsurance for Intensive Cardiac Rehabilitation services</p> <p>This applies to program services provided in a doctor's office. Specified cost sharing for program services provided by hospital outpatient departments.</p>	<p>General</p> <p>Authorization rules may apply.</p> <p>In-Network</p> <p>0% or 20% of the cost for Medicare-covered Cardiac Rehabilitation Services*</p> <p>0% or 20% of the cost for Medicare-covered Intensive Cardiac Rehabilitation Services*</p> <p>0% or 20% of the cost for Medicare-covered Pulmonary Rehabilitation Services*</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
<p>23. Preventive Services and Wellness/Education Programs</p>	<p>No coinsurance, copayment or deductible for the following:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm Screening • Bone Mass Measurement. Covered once every 24 months (more often if medically necessary) if you meet certain medical conditions • Cardiovascular Screening • Cervical and Vaginal Cancer Screening. Covered once every 2 years. Covered once a year for women with Medicare at high risk. • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine for people with Medicare who are at risk 	<p>General</p> <p>\$0 copay for all preventive services covered under Original Medicare at zero cost sharing:</p> <ul style="list-style-type: none"> • Abdominal Aortic Aneurysm screening • Bone Mass Measurement • Cardiovascular Screening • Cervical and Vaginal Cancer Screening (Pap Test and Pelvic Exam) • Colorectal Cancer Screening • Diabetes Screening • Influenza Vaccine • Hepatitis B Vaccine • HIV Screening • Breast Cancer Screening (Mammogram) • Medical Nutrition Therapy Services

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
	<ul style="list-style-type: none"> • HIV Screening. \$0 copay for the HIV screening, but you generally pay 20% of the Medicare-approved amount for the doctor’s visit. HIV screening is covered for people with Medicare who are pregnant and people at increased risk for the infection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. • Breast Cancer Screening (Mammogram). Medicare covers screening mammograms once every 12 months for all women with Medicare age 40 and older. Medicare covers one baseline mammogram for women between ages 35-39. 	<ul style="list-style-type: none"> • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine • Prostate Cancer Screening (Prostate Specific Antigen (PSA) test only) • Smoking Cessation (Counseling to stop smoking if ordered by a doctor) • Welcome to Medicare Physical Exam (Initial HIV screening is covered for people with Medicare who are pregnant and people at increased risk for theinfection, including anyone who asks for the test. Medicare covers this test once every 12 months or up to three times during a pregnancy. Please contact plan for details.

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
	<ul style="list-style-type: none"> • Medical Nutrition Therapy Services 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 and may include a nutritional assessment and counseling to help you manage your diabetes or kidney disease • Personalized Prevention Plan Services (Annual Wellness Visits) • Pneumococcal Vaccine. You may only need the Pneumonia vaccine once in your lifetime. Call your doctor for more information. • Prostate Cancer Screening Prostate Specific Antigen (PSA) test only. Covered once a year for all men with Medicare over age 50. 	<p>In-Network</p> <p>The plan covers the following supplemental education/wellness programs:</p> <ul style="list-style-type: none"> • Written health education materials, including Newsletters • Health Club Membership/ Fitness Classes

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
	<ul style="list-style-type: none"> • Smoking Cessation (counseling to stop smoking). Covered if ordered by your doctor. Includes two counseling attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. • Welcome to Medicare Physical Exam (initial preventive physical exam) When you join Medicare Part B, then you are eligible as follows. During the first 12 months of your new Part B coverage, you can get either a Welcome to Medicare Physical Exam or an Annual Wellness Visit. After your first 12 months, you can get one Annual Wellness Visit every 12 	

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
24. Kidney Disease and Conditions	0% or 20% coinsurance for renal dialysis 0% or 20% coinsurance for kidney disease education services	In-Network 0% or 20% of the cost for renal dialysis* 0% or 20% of the cost for kidney disease education services*
25. Outpatient Prescription Drugs	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.	Drugs covered under Medicare Part B General \$0 annual deductible for Part B-covered drugs.* 0% or 20% of the cost for Part B-covered chemotherapy drugs and other Part B-covered drugs.* 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 www.elderplan.org on the web.

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<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, <p>or</p> <ul style="list-style-type: none"> - have access to Indian/ Tribal/Urban (Indian Health Service) providers. <p>The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). 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>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare.</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 Elderplan For Medicaid Beneficiaries (HMO SNP) for certain drugs.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, 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</p> <p>You pay a \$0 annual deductible.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Initial Coverage Depending on your income and institutional status, you pay the following: For generic drugs (including brand drugs treated as generic), either: - A \$0 copay; or - A \$1.10 copay; or - A \$2.60 copay For all other drugs, either: - A \$0 copay; or - A \$3.30 copay; or - A \$6.50 copay.</p> <p>Retail Pharmacy You can get drugs the following way(s): - one-month (30-day) supply - three-month (90-day) supply</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Long-Term Care Pharmacy You can get drugs the following way(s): - one-month (31-day) supply</p> <p>Mail Order You can get drugs the following way(s): - three-month (90-day) supply</p> <p>Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you pay a \$0 copay.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Out-of-Network</p> <p>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 Elderplan For Medicaid Beneficiaries (HMO SNP). You can get drugs the following way:</p> <ul style="list-style-type: none"> - one-month (30-day) supply

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Out-of-Network Initial Coverage</p> <p>Depending on your income and institutional status, you will be reimbursed by Elderplan For Medicaid Beneficiaries (HMO SNP) up to the plan's cost of the drug minus the following:</p> <p>For generic drugs purchased out-of-network (including brand drugs treated as generic), either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$1.10 copay; or - A \$2.60 copay <p>For all other drugs purchased out-of-network, either:</p> <ul style="list-style-type: none"> - A \$0 copay; or - A \$3.30 copay; or - A \$6.50 copay.

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
		<p>Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach \$4,700, you will be reimbursed in full for drugs purchased out-of-network.</p>
26. Dental Services	Preventive dental services (such as cleaning) not covered.	<p>In-Network \$0 copay for Medicare-covered dental benefits* In general, preventive dental benefits (such as cleaning) not covered.</p>
27. Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 0% or 20% coinsurance for diagnostic hearing exams.	<p>General Authorization rules may apply.</p> <p>In-Network \$0 copay for up to 1 hearing aid(s) every three years - 0% or 20% of the cost for Medicare-covered diagnostic hearing exams* \$1,500 plan coverage limit for hearing aids.</p>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
28. Vision Services	<p>0% or 20% coinsurance for diagnosis and treatment of diseases and conditions of the eye.</p> <p>Supplemental routine eye exams and glasses not covered.</p> <p>Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.</p> <p>Annual glaucoma screenings covered for people at risk.</p>	<p>In-Network</p> <p>\$0 copay for</p> <ul style="list-style-type: none"> - one pair of eyeglasses or contact lenses after cataract surgery * - glasses - contacts - lenses - frames - 0% or 20% of the cost for exams to diagnose and treat diseases and conditions of the eye.* <p>\$100 plan coverage limit for eye wear every year.</p>
Over-the-Counter Items	Not covered.	<p>General</p> <p>Please visit our plan website to see our list of covered Over-the-Counter items.</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>

Benefit Category	Original Medicare	Elderplan For Medicaid Beneficiaries (HMO SNP)
PREVENTIVE SERVICES		
Transportation (Routine)	Not covered.	In-Network This plan does not cover supplemental routine transportation.
Acupuncture	Not covered.	In-Network \$0 copay for up to 50 visit(s) every year

Section III: Extra Benefits

Members of Elderplan for Medicaid Beneficiaries also have access to the following valuable benefits:

Silver&Fit Basic Fitness Club or Exercise Center Access

Staying fit and active helps you remain healthy. That's why, as a supplemental benefit, Elderplan gives members of this plan access to our special Silver&Fit Program at no cost. The Silver&Fit Program offers each beneficiary membership at a participating fitness club or exercise center. The Silver&Fit Basic network is national in scope and includes over 10,000 fitness clubs and 2,700 exercise centers for Elderplan members to choose from. These valuable fitness club memberships include standard fitness club services including access to cardiovascular equipment; free weights; resistance training equipment; group exercise classes; and, where available, amenities such as saunas, steam rooms, and whirlpools. The exercise center memberships offer access to the standard services offered by the exercise center such as Jazzercise, Pilates, yoga, or other.

Elderplan OTC Catalog

Over the Counter (OTC) drug costs can mount up quickly. That is why Elderplan offers members of this plan a credit of up to \$120 per quarter to all eligible members to take advantage of our OTC catalog. This catalog allows our members to purchase certain everyday pharmacy items which are not covered under your Medicare Part B or Part D prescription drug coverage benefits. Items found in the OTC catalog include cough & cold remedies, first aid items, vitamins and many other available items to choose from. To request a copy of the OTC catalog please call 1-866-417-3064 (TTY 866-763-9630) 24 hours a day 7 days a week. If you have Medicaid, some health products listed in the catalog may be available to you through Medicaid using your Medicaid Benefit ID card.

Section IV: Additional Information for People with Medicare and Medicaid

People who qualify for Medicare and Medicaid are known as dual eligibles. As a dual eligible, you are eligible for benefits under both the federal Medicare program and the state-operated Medicaid program. The Original Medicare and supplemental benefits you receive as a member of this plan are listed in Section II. The kind of Medicaid benefits you receive are determined by your state and may vary based upon your income and resources. With the assistance of Medicaid, some dual eligibles do not have to pay for certain Medicare costs. The Medicaid benefit categories and type of assistance served by our plan are listed below:

- **Full Benefit Dual Eligible (FBDE):** Payment of your Medicare Part B premiums, in some cases Medicare Part A premiums and full Medicaid benefits.
- **Qualified Disabled and Working Individual (QDWI):** Payment of your Medicare Part A premiums.
- **Qualifying Individual (QI):** Payment of your Medicare Part B premiums.
- **Specified Low Income Medicare Beneficiary (SLMB):** Payment of your Medicare Part B premiums.
- **SLMB-Plus:** Payment of your Medicare Part B premiums and full Medicaid benefits.
- **Qualified Medicare Beneficiary (QMB Only):** Payment of your Medicare Part A and/or Part B premiums, deductibles and cost-sharing (excluding Part D copayments).
- **QMB-Plus:** Payment of your Medicare Part A and Part B premiums, deductibles, cost-sharing (excluding Part D copayments) and full Medicaid benefits.

The following chart lists services that are available under Medicaid for people who qualify for full Medicaid benefits. The chart also explains if a similar benefit is available under our plan.

It is important to understand that Medicaid benefits can vary based on your income level and other standards. Also, your Medicaid benefits can change throughout the year. Depending on your current status, you may not be qualified for all Medicaid benefits. However, while a member of our plan, you can access plan benefits regardless of your Medicaid status. You may contact New York City Human Resources Administration at 1-877-472-8411 for the most current and accurate information regarding your eligibility and benefits.

Comprehensive Written Statement for people with Medicare and Medicaid

In order to qualify for enrollment in the Elderplan for Medicaid Beneficiaries (HMO SNP) Plan you must participate in the New York State Medicaid Program. The Medicare Advantage benefits and cost-sharing protections you receive as a member of this plan are listed in the above two sections entitled Introduction to the Summary of Benefits Report and Important Information. The below chart, Medicaid Benefits and Cost-sharing, describes Medicaid benefits that you may be entitled to depending on your level of Medicaid under the New York State Medicaid program. If you have any questions concerning what benefits you are entitled to under the Medicaid program, please call the New York City Medicaid staff the Human Resources Administration at 1-877-474-8411.

Benefit Category	Medicaid Fee for Service
Inpatient Hospital Care including Substance Abuse and Rehabilitation Services	Medicaid covers Medicare deductibles, copays and coinsurances. Up to 365 days per year (366 days for leap year)
Skilled Nursing Facility (SNF)	Medicaid covers Medicare deductibles, copays and coinsurances. Medicaid covers additional days beyond Medicare 100 day limit.
Doctor Office Visits	Medicaid covers Medicare deductibles, copays and coinsurances.
Podiatry Services	Medicaid covers Medicare deductibles, copays and coinsurances (QMB and QMB-Plus Only)
Chiropractic Services	Medicaid covers Medicare deductibles, copays and coinsurances (QMB and QMB-Plus Only)
Outpatient Substance Abuse Care	Medicaid covers Medicare deductibles, copays and coinsurances.
Outpatient Mental Health	Medicaid covers Medicare deductibles, copays and coinsurances
Outpatient Services/Surgery	Medicaid covers Medicare deductibles, copays and coinsurances.
Ambulance Services	Medicaid covers Medicare deductibles, copays and coinsurances.
Emergency Care	Medicaid covers Medicare deductibles, copays and coinsurances.
Urgently Needed Care	Medicaid covers Medicare deductibles, copays, and coinsurances.

Benefit Category	Medicaid Fee for Service
Outpatient Rehabilitation Services	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p> <p>Occupational, Physical and Speech therapies are limited to twenty (20) visits per therapy per year, except for children under age 21, or you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.</p>
Prosthetic Devices	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p> <p>Medicaid covered prosthetics, orthotics, and orthopedic footwear. Prescription footwear coverage is limited to treatment of diabetics or when a shoe is part of a leg brace (orthotic) or if there are foot complications in children under age 21.</p>
Diabetes Self-Monitoring Training, Nutrition Therapy, and Supplies	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p>
Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p>
Bone Mass Measurement	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p>
Colorectal Screening Exams	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p>
Immunizations	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p>

Benefit Category	Medicaid Fee for Service
Mammograms	Medicaid covers Medicare deductibles, copays and coinsurances.
Pap Smears and Pelvic Exams	Medicaid covers Medicare deductibles, copays and coinsurances.
Prostate Cancer Screening Exams	Medicaid covers Medicare deductibles, copays and coinsurances.
End Stage Renal Disease	Medicaid covers Medicare deductibles, copays and coinsurances.
Prescription Drugs	<p>Medicaid does not cover Part D covered drugs or copays.</p> <p>Medicaid Pharmacy Benefits allowed by State Law (select drug categories excluded from the Medicare Part D benefit). Certain Medical Supplies and Enteral Formula when not covered by Medicare.</p>
Over the Counter Drugs	Certain Over the Counter medications are covered.
Dental	<p>Medicaid covers Medicare deductibles, copays and coinsurances</p> <p>Medicaid covered dental services including necessary preventive, prophylactic and other routine dental care, services, and supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.</p>

Benefit Category	Medicaid Fee for Service
Transportation (Routine)	Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee’s medical condition.
Inpatient Mental Health Services (over 190-day lifetime limit)	<p>Medicaid covered Medicare deductibles, copays and coinsurances</p> <p>All inpatient mental health services, including voluntary or involuntary admissions for mental health services over the Medicare 190 day lifetime limit.</p>
Non-Medicare Covered Home Health Services	<p>Medicaid covered Medicare deductibles, copays and coinsurances</p> <p>Medically necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Also includes non-Medicare covered home health services (e.g. home health aid services with nursing supervision to medically unstable individuals)</p>

Benefit Category	Medicaid Fee for Service
Non-Medicare Covered Durable Medical Equipment	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p> <p>Medicaid covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g. tub stool; grab bar)</p>
Private Duty Nursing Services	<p>Private duty nursing services are covered when determined by the physician to be medically necessary. Nursing services can be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. Nursing services may be intermittent, part time or continuous and must be provided in an Enrollee's home in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.</p>

Benefit Category	Medicaid Fee for Service
Non-Medicare Covered Hearing Services	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p> <p>Hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing and selecting, fitting, and dispensing, hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.</p>
Non-Medicare Covered Vision Services	<p>Medicaid covers Medicare deductibles, copays and coinsurances.</p> <p>Services of Optometrists, Ophthalmologists, and Ophthalmic dispensers including eyeglasses, medically necessary contact lenses and polycarbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts. Coverage also includes examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two (2) years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two (2) years unless medically necessary or unless the glasses are lost, damaged or destroyed.</p>

Benefit Category	Medicaid Fee for Service
Hospice	Medicaid covers Medicare deductibles, copays and coinsurances.
Physical Exams	Medicaid covered Medicare deductibles, copays and coinsurances.
Health/Wellness Education	No coverage
Out-of-Network Family Planning services provided under the direct access provisions of the waiver	Medicaid coverage provided
Personal Care Services	<p>Medicaid coverage provided</p> <p>Provides some or total assistance with such activities as personal hygiene, dressing and feeding and nutritional and environmental support function tasks. Services must be medically necessary and ordered by the enrollee’s physician and provided by a qualified person.</p>
Certain Mental Health Services	<p>Medicaid coverage of Certain Mental Health Services includes:</p> <ul style="list-style-type: none"> • Intensive Psychiatric Rehabilitation Treatment Programs, • Day Treatment, • Continuing Day Treatment, • Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units), • Partial Hospitalizations, • Assertive Community Treatment (ACT), • Personalized Recovery Oriented Services (PROS)

Benefit Category	Medicaid Fee for Service
Methadone Maintenance Treatment Programs (MMTP)	Medicaid coverage provided
Rehabilitation Services Provided to Residents of OMH Licensed Community Residence (CRs) and Family Based Treatment Programs	Medicaid coverage provided
Office for People with Developmental Disabilities (OPWDD) Services	Medicaid coverage provided
Comprehensive Medicaid Case Management	Medicaid coverage provided
Directly Observed Therapy for Tuberculosis (TB) Disease	Medicaid coverage provided
AIDS Adult Day Health Care	Medicaid coverage provided
HIV COBRA Case Management	Medicaid coverage provided
Assisted Living Program	Medicaid coverage provided
Adult Day Health Care	Medicaid coverage provided
Personal Emergency Response Services (PERS)	<p>Medicaid coverage provided</p> <p>An electronic device which enables certain high risk patients to secure help in the event of a physical, emotional or environmental emergency. A variety of electronic alert systems exist using different signaling devices. Such systems are usually connected to a patient’s phone and signal a response center when a “help” button is activated. In the event of an emergency, the signal is received and appropriately acted on by a response center.</p>



To contact the **Sales Department**, call **1-866-360-1934**.

If you're hearing impaired, call **TTY 1-800-662-1220**.

Department hours are 8 a.m.–8 p.m., 7 days a week.

To contact the **Member Service Department**, call **1-800-353-3765**.

If you're hearing impaired, call **TTY 1-800-662-1220**.

Department hours are 8 a.m.–8 p.m., 7 days a week.

A Coordinated Care plan with a Medicare Advantage contract and a contract with the NY State Medicaid program. Anyone entitled to Medicare Parts A and B may apply. Enrolled members must continue to pay their Medicare part B premium if not otherwise paid for under Medicaid.