2024 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage
MediGold Cash Back No Premium (HMO)
MediGold No Premium (HMO)
MediGold Plus (HMO)

January 1, 2024 – December 31, 2024

Select Counties in New York: Cash Back No Premium HMO, No Premium HMO and Plus HMO (serving Albany, Lewis, Madison, Montgomery, Oneida, Onondaga, Rensselaer and Schenectady counties in New York)

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the **"Evidence of Coverage"**. You can also see the Evidence of Coverage on our website, www.medigold.com/for-members/member-materials/new-york/.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO) and MediGold Plus (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO)** and **MediGold Plus (HMO)** cover and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on https://www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at https://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO)** and **MediGold Plus (HMO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug Benefits

This document is available in other formats such as Braille and large print.
This document may be available in a non-English language. For additional information, call us at 1-800-240-3851 (TTY: 711). Hours are 8 a.m. - 8 p.m., 7 days a week. On certain holidays, your call will be handled by our automated phone system.

Things to Know About MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO) and MediGold Plus (HMO)

Hours of Operation & Contact Information

- We're open 8 a.m. – 8 p.m. local time, 7 days a week.
- If you are a member of this plan, call us at 1-800-240-3851, TTY: 711.
- If you are not a member of this plan, call us at 1-800-964-4525, TTY: 711.
- Our website:www.medigold.com

Who can join?

To join **MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO) and MediGold Plus (HMO)**, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for **MediGold Cash Back No Premium (HMO)** includes the following counties in New York: Albany, Lewis, Madison, Montgomery, Oneida, Onondaga, Rensselaer and Schenectady.
The service area for **MediGold No Premium (HMO)** includes the following counties in New York: Albany, Lewis, Madison, Montgomery, Oneida, Onondaga, Rensselaer and Schenectady.
The service area for **MediGold Plus (HMO)** includes the following counties in New York: Albany, Lewis, Madison, Montgomery, Oneida, Onondaga, Rensselaer and Schenectady.

Which doctors, hospitals, and pharmacies can I use?

MediGold Cash Back No Premium (HMO), MediGold No Premium (HMO) and **MediGold Plus (HMO)** have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.medigold.com/find-a-provider).

Or, call us and we will send you a copy of the provider and pharmacy directories.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

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

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.medigold.com/pharmacy-and-drug-benefits/formulary.
- Or, call us and we will send you a copy of the formulary.

How will I determine my drug costs?

Our plan groups each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact MediGold

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	You do not pay a separate monthly plan premium for MediGold Cash Back No Premium (HMO). You must continue to pay your Medicare Part B premium.	You do not pay a separate monthly plan premium for MediGold No Premium (HMO). You must continue to pay your Medicare Part B premium.	$29 per month. In addition, you must keep paying your Medicare Part B premiums.
Part B Premium Reduction	Your plan will reduce your Medicare Part B premium by up to $60 per month.	Not Applicable.	Not Applicable.
Deductible	Medical Deductible: Not Applicable. Prescription Drug Deductible: $275 for Tiers 3, 4 and 5.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.	Medical Deductible: Not Applicable. Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $7,300 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $6,200 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Your yearly limit(s) in this plan: • $5,500 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
COVERED MEDICAL AND HOSPITAL BENEFITS			
Inpatient Hospital	**In-Network:** Days 1-5: $370 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.	**In-Network:** Days 1-5: $300 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.	**In-Network:** Days 1-5: $275 copay per day for each admission. Days 6-90: $0 copay per day. Our plan covers an unlimited number of days for an inpatient hospital stay. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $0 - $350 copay. Outpatient Surgery: $350 copay.	**In-Network:** Outpatient hospital: $0 - $295 copay. Outpatient Surgery: $295 copay.	**In-Network:** Outpatient hospital: $0 - $275 copay. Outpatient Surgery: $275 copay.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $350 copay.	**In-Network:** Ambulatory Surgical Center: $295 copay.	**In-Network:** Ambulatory Surgical Center: $275 copay.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $45 copay.	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $30 copay.	**In-Network:** Primary care physician visit: $0 copay. Specialist visit: $25 copay.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
Preventive Care (e.g., flu vaccine, diabetic screenings)	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** You pay nothing for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** $90 copay per visit. If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 copay.	**In-Network:** $90 copay per visit. If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 copay.	**In-Network:** $90 copay per visit. If you are admitted to the hospital within 48 hours, you do not have to pay your share of the cost for emergency care. Worldwide Emergency Coverage: $90 copay.
Urgently Needed Services	**In-Network:** $40 copay per visit. Worldwide Urgent Coverage: $90 copay.	**In-Network:** $30 copay per visit. Worldwide Urgent Coverage: $90 copay.	**In-Network:** $25 copay per visit. Worldwide Urgent Coverage: $90 copay.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $40 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $250 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $30 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $170 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $25 copay. Lab services: $0 copay. Diagnostic Radiology Services (such as MRI, CAT Scan): $145 copay. X-rays: $0 copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% coinsurance. May require prior authorization.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $45 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $599 - $899 copay.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $30 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $599 - $899 copay.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $25 copay. Routine hearing exam (up to 1 visit(s) every year): $0 copay. Hearing Aid (up to 2 hearing aids every year): $399 - $699 copay.
Dental Services	**In-Network:** Preventive Dental Services: • Oral exam (up to 2 visits every year): $0 copay.	**In-Network:** Preventive Dental Services: • Oral exam (up to 2 visits every year): $0 copay.	**In-Network:** Preventive Dental Services: • Oral exam (up to 2 visits every year): $0 copay.

SECTION II - SUMMARY OF BENEFITS			
	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
	• Cleaning (up to 2 visits every year): $0 copay. • Dental X-rays: $0 copay. Comprehensive Dental Services: • Diagnostic Services: $0 copay. • Restorative Services: 50% coinsurance. • Extraction: 50% coinsurance. This dental plan will pay up to $1,000 maximum plan coverage limit per calendar year Medicare Covered: $45 copay.	• Cleaning (up to 2 visits every year): $0 copay. • Dental X-rays: $0 copay. Comprehensive Dental Services: • Diagnostic Services: $0 copay. • Restorative Services: 50% coinsurance. • Extraction: 50% coinsurance. • Endodontics: 70% coinsurance. • Periodontics: 70% coinsurance. This dental plan will pay up to $1,000 maximum plan coverage limit per calendar year Medicare Covered: $30 copay.	• Cleaning (up to 2 visits every year): $0 copay. • Dental X-rays: $0 copay. Comprehensive Dental Services: • Diagnostic Services: $0 copay. • Restorative Services: 50% coinsurance. • Extraction: 50% coinsurance. • Endodontics: 70% coinsurance. • Periodontics: 70% coinsurance. This dental plan will pay up to $1,000 maximum plan coverage limit per calendar year Medicare Covered: $25 copay.
OPTIONAL SUPPLEMENTAL DENTAL SERVICES			
Optional Supplemental Dental Services	Not Applicable.	Enhanced Comprehensive Dental Services: • Diagnostic Services: $0 copay. • Restorative Services: 0% - 50% coinsurance.	Enhanced Comprehensive Dental Services: • Diagnostic Services: $0 copay. • Restorative Services: 0% - 50% coinsurance.

SECTION II - SUMMARY OF BENEFITS			
	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
		• Endodontics: 50% coinsurance. • Periodontics: 50% coinsurance. • Extractions: 50% coinsurance. • Crowns/Bridges/ Dentures: 50% coinsurance (Dental Gold Only)	• Endodontics: 50% coinsurance. • Periodontics: 50% coinsurance. • Extractions: 50% coinsurance. • Crowns/Bridges/ Dentures: 50% coinsurance (Dental Gold Only)
How much is the monthly premium?	Not Applicable.	**Dental Silver:** If you elect this optional supplemental benefit, you will pay an additional $17.80 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium. **Dental Gold:** If you elect this optional supplemental benefit, you will pay an additional $44 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium. Call for details!	**Dental Silver:** If you elect this optional supplemental benefit, you will pay an additional $17.80 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium. **Dental Gold:** If you elect this optional supplemental benefit, you will pay an additional $44 per month. You must also keep paying your Medicare Part B premium and your plan monthly premium. Call for details!
How much is the deductible?	Not Applicable.	There is no deductible.	There is no deductible.
What is the maximum payment that this plan will pay per calendar year?	Not Applicable.	This dental plan will pay up to $1,500 maximum plan	This dental plan will pay up to $1,500 maximum plan

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
		coverage limit per calendar year for Dental Silver. This dental plan will pay up to $2,000 maximum plan coverage limit per calendar year for Dental Gold.	coverage limit per calendar year for Dental Silver. This dental plan will pay up to $2,000 maximum plan coverage limit per calendar year for Dental Gold.
COVERED MEDICAL AND HOSPITAL BENEFITS (Continued)			
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $45 copay. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Eyeglass lenses: $0 copay. Eyeglass frames: $0 copay. Our plan pays up to $150 every year for eyewear.	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $30 copay. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Eyeglass lenses: $0 copay. Eyeglass frames: $0 copay. Our plan pays up to $200 every year for eyewear.	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0 - $25 copay. Routine eye exam (up to 1 visit(s) every year): $0 copay. Eyeglasses or contact lenses after cataract surgery: $0 copay. Contact lenses: $0 copay. Eyeglasses (frames and lenses): $0 copay. Eyeglass lenses: $0 copay. Eyeglass frames: $0 copay. Our plan pays up to $250 every year for eyewear.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
Mental Health Care	**In-Network:** Outpatient group therapy visit: $40 copay. Individual therapy visit: $40 copay. Inpatient Mental Health Care: Days 1-5: $370 copay per day for each admission. Days 6-90: $0 copay per day. May require prior authorization.	**In-Network:** Outpatient group therapy visit: $30 copay. Individual therapy visit: $30 copay. Inpatient Mental Health Care: Days 1-5: $300 copay per day for each admission. Days 6-90: $0 copay per day. May require prior authorization.	**In-Network:** Outpatient group therapy visit: $25 copay. Individual therapy visit: $25 copay. Inpatient Mental Health Care: Days 1-5: $275 copay per day for each admission. Days 6-90: $0 copay per day. May require prior authorization.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 copay per day. Days 21-56: $203 copay per day. Days 57-100: $0 copay per day.	**In-Network:** Days 1-20: $0 copay per day. Days 21-56: $203 copay per day. Days 57-100: $0 copay per day.	**In-Network:** Days 1-20: $0 copay per day. Days 21-56: $203 copay per day. Days 57-100: $0 copay per day.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay.	**In-Network:** Occupational therapy visit: $30 copay. Physical therapy and speech and language therapy visit: $30 copay.	**In-Network:** Occupational therapy visit: $25 copay. Physical therapy and speech and language therapy visit: $25 copay.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
Ambulance	**In-Network:** Ground Ambulance: $300 copay. Air Ambulance: $350 copay. May require prior authorization.	**In-Network:** Ground Ambulance: $240 copay. Air Ambulance: $290 copay. May require prior authorization.	**In-Network:** Ground Ambulance: $220 copay. Air Ambulance: $270 copay. May require prior authorization.
Transportation	**In-Network:** Not Covered.	**In-Network:** Not Covered.	**In-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% coinsurance. Other Part B drugs: 0% - 20% coinsurance. Part B Drugs - Insulin: $35 copay. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% coinsurance. Other Part B drugs: 0% - 20% coinsurance. Part B Drugs - Insulin: $35 copay. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 0% - 20% coinsurance. Other Part B drugs: 0% - 20% coinsurance. Part B Drugs - Insulin: $35 copay. May require prior authorization.
Foot Care *(podiatry services)*	**In-Network:** Foot exams: $45 copay.	**In-Network:** Foot exams: $30 copay.	**In-Network:** Foot exams: $25 copay.
Durable Medical Equipment	**In-Network:** 20% coinsurance. May require prior authorization.	**In-Network:** 20% coinsurance. May require prior authorization.	**In-Network:** 20% coinsurance. May require prior authorization.

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
Prosthetic Devices *(braces, artificial limbs, etc.)*	**In-Network:** Prosthetic devices: 20% coinsurance. Related medical supplies: 20% coinsurance. May require prior authorization.	**In-Network:** Prosthetic devices: 20% coinsurance. Related medical supplies: 20% coinsurance. May require prior authorization.	**In-Network:** Prosthetic devices: 20% coinsurance. Related medical supplies: 20% coinsurance. May require prior authorization.
Diabetes Supplies and Services	**In-Network:** Diabetes monitoring supplies: $0 copay. Diabetes self-management training: $0 copay. Therapeutic shoes or inserts: 20% coinsurance. May require prior authorization.	**In-Network:** Diabetes monitoring supplies: $0 copay. Diabetes self-management training: $0 copay. Therapeutic shoes or inserts: 20% coinsurance. May require prior authorization.	**In-Network:** Diabetes monitoring supplies: $0 copay. Diabetes self-management training: $0 copay. Therapeutic shoes or inserts: 20% coinsurance. May require prior authorization.
Wellness Program	**In-Network:** Fitness Benefit: $0 copay.	**In-Network:** Fitness Benefit: $0 copay.	**In-Network:** Fitness Benefit: $0 copay.
Meal Benefit	**In-Network:** 2 meals per day for 7 days, immediately following a qualifying discharge. $0 Copay. Must utilize GA Foods® to access this benefit.	**In-Network:** 2 meals per day for 7 days, immediately following a qualifying discharge. $0 Copay. Must utilize GA Foods® to access this benefit.	**In-Network:** 2 meals per day for 7 days, immediately following a qualifying discharge. $0 Copay. Must utilize GA Foods® to access this benefit.
PRESCRIPTION DRUG BENEFITS			
Part D Insulin Coverage	You won't pay more than $35 for a one-month supply	You won't pay more than $35 for a one-month supply	You won't pay more than $35 for a one-month

<table>
<tr><th colspan="4">SECTION II - SUMMARY OF BENEFITS</th></tr>
<tr><th></th><th>MediGold Cash Back No Premium (HMO)</th><th>MediGold No Premium (HMO)</th><th>MediGold Plus (HMO)</th></tr>
<tr><td></td><td>of each covered insulin product regardless of the cost-sharing tier.</td><td>of each covered insulin product regardless of the cost-sharing tier.</td><td>supply of each covered insulin product regardless of the cost-sharing tier.</td></tr>
<tr><td>ED Drug Coverage</td><td>Included! Call for details.</td><td>Included! Call for details.</td><td>Included! Call for details.</td></tr>
<tr><td>Deductible</td><td>$275 (applies to tiers 3, 4 and 5). For Tier 3, 4 and 5 drugs, you will pay the full cost of the drug until you have met your $275 deductible.</td><td>Not Applicable.</td><td>Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing
<table><tr><th>Tier</th><th>One-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$5 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>29% coinsurance</td></tr></table></td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

Standard Retail Cost-Sharing
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Standard Retail Cost-Sharing
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SECTION II - SUMMARY OF BENEFITS

	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)

MediGold Cash Back No Premium (HMO)

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$15 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Drug)	$300 copay

MediGold No Premium (HMO)

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$15 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Drug)	$300 copay

MediGold Plus (HMO)

Tier	Two-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$10 copay
Tier 3 (Preferred Brand)	$94 copay
Tier 4 (Non-Preferred Drug)	$200 copay
Tier 5 (Specialty Tier)	Not Applicable

Tier	Three-month supply
Tier 1 (Preferred Generic)	$0 copay
Tier 2 (Generic)	$15 copay
Tier 3 (Preferred Brand)	$141 copay
Tier 4 (Non-Preferred Drug)	$300 copay

SECTION II - SUMMARY OF BENEFITS

	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
	Tier 5 (Specialty Tier): Not Applicable	Tier 5 (Specialty Tier): Not Applicable	Tier 5 (Specialty Tier): Not Applicable
	Standard Mail Order	**Standard Mail Order**	**Standard Mail Order**
	Tier / **One-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $47 copay Tier 4 (Non-Preferred Drug): $100 copay Tier 5 (Specialty Tier): 29% coinsurance	**Tier** / **One-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $47 copay Tier 4 (Non-Preferred Drug): $100 copay Tier 5 (Specialty Tier): 33% coinsurance	**Tier** / **One-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $47 copay Tier 4 (Non-Preferred Drug): $100 copay Tier 5 (Specialty Tier): 33% coinsurance
	Tier / **Two-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay	**Tier** / **Two-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay	**Tier** / **Two-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay

SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
	Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable	Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable	Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable
	Tier / **Three-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable	**Tier** / **Three-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable	**Tier** / **Three-month supply** Tier 1 (Preferred Generic): $0 copay Tier 2 (Generic): $0 copay Tier 3 (Preferred Brand): $94 copay Tier 4 (Non-Preferred Drug): $200 copay Tier 5 (Specialty Tier): Not Applicable
	Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 31 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website	Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 31 days) of a drug. Please call us or see the plan's **"Evidence of Coverage"** on our website	Your cost-sharing may be different if you use a Long Term Care pharmacy, or an out-of-network pharmacy, or if you purchase a long-term supply (up to 31 days) of a drug. Please call us or see the plan's **"Evidence of**

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<tr><td></td><td>(www.medigold.com/for-members/member-materials/new-york/) for complete information about your costs for covered drugs.</td><td>(www.medigold.com/for-members/member-materials/new-york/) for complete information about your costs for covered drugs.</td><td>Coverage” on our website (www.medigold.com/for-members/member-materials/new-york/) for complete information about your costs for covered drugs.</td></tr>
<tr><td>Coverage Gap</td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap.
Standard Retail Cost-Sharing<table><tr><th>Tier</th><th>One-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr></table></td><td>The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. After you enter the coverage gap, you pay 25% of the plan's cost for covered brand name drugs and 25% of the plan's cost for covered generic drugs until your costs total $8,000, which is the end of the coverage gap.
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SECTION II - SUMMARY OF BENEFITS	MediGold Cash Back No Premium (HMO)	MediGold No Premium (HMO)	MediGold Plus (HMO)
	• During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay Tier 2 copay.	• During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay Tier 2 copay.	• During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing. • For excluded drugs covered under our enhanced benefit, you pay Tier 2 copay.
SUPPLEMENTAL BENEFITS AND SERVICES			
Flex Card – Including Member Rewards/ Incentive and Supplemental Vision/ Hearing Allowance	**In-Network:** Included! Call for details.	**In-Network:** Included! Call for details.	**In-Network:** Included! Call for details.
Over-the-Counter (OTC) Allowance	**In-Network:** $0 copay. $110 per quarter, no carry over.	**In-Network:** $0 copay. $105 per quarter, no carry over.	**In-Network:** $0 copay. $110 per quarter, no carry over.
24 Hour Nurse Advice Line + Virtual Care Visits	**In-Network:** $0 Copay	**In-Network:** $0 Copay	**In-Network:** $0 Copay
Visitor Travel Allowance	**In-Network:** $1,500.	**In-Network:** $2,500.	**In-Network:** $3,000.
Acupuncture	**In-Network:** $20 copay, 6 visit(s) every year. May require prior authorization.	**In-Network:** $20 copay, 6 visit(s) every year. May require prior authorization.	**In-Network:** $20 copay, 12 visit(s) every year. May require prior authorization.

DISCLAIMERS

This document is available in other alternate format.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-800-240-3851 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-800-964-4525 (TTY: 711).

MediGold Cash Back No Premium (HMO), **MediGold No Premium (HMO)** and **MediGold Plus (HMO)** are HMO plans with a Medicare contract. Enrollment in **MediGold Cash Back No Premium (HMO)**, **MediGold No Premium (HMO)** and **MediGold Plus (HMO)** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat MediGold members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your "Evidence of Coverage" for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Mount Carmel Health Plan Of New York, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-800-964-4525 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.medigold.com/for-members/member-materials/new-york/ or call 1-800-964-4525 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ **Effect on Current Coverage.** Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

NON-DISCRIMINATION NOTICE

MediGold complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, sex (defined as sex at birth, legal sex and/or sex stereotyping), and gender (which includes gender identity, gender expression and/or pregnancy). MediGold does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, sex or gender. MediGold:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
    - Provides free language services to people whose primary language is not English, such as:
        - Qualified interpreters
        - Information written in other languages

If you need these services, contact Member Services.

If you believe that MediGold has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, sex or gender, you can file a grievance with: Daniel Hayes, Member Services Manager, 3100 Easton Square Place, Third Floor - Health Plan, Columbus, OH 43219, 1-800-240-3851 (TTY 711), 1-833-802-2200 fax, HealthPlanAppeals@trinity-health.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Daniel Hayes, Member Services Manager, is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at *www.hhs.gov/ocr/complaints/index.html*

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-240-3851 (TTY 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-240-3851 (TTY 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-240-3851 (TTY 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-240-3851 (TTY 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-240-3851 (TTY 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-240-3851 (TTY 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-240-3851 (TTY 711). sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-240-3851 (TTY 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-240-3851 (TTY 711). 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-240-3851 (TTY 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-240-3851 (TTY 711).. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-240-3851 (TTY 711). पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-240-3851 (TTY 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-240-3851 (TTY 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-240-3851 (TTY 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-240-3851 (TTY 711).. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあり ますございます。通訳をご用命になるには、
1-800-240-3851 (TTY 711).にお電話く ださい。日本語を話す人者が支援いたし ます。これは無料のサー ビスです。

Somali: Waxaan leenahay adeegyo turjumaan oo lacag la'aan ah si aan uga jawaabno su'aalo kasta oo aad ka qabtid caafimaadkayaga ama qorshahayaga daawo ahaaneed. Si aad u hesho turjumaan, kaliya naga soo wac 1-800-240-3851 (TTY 711). Qof ku hadla luuqada Soomaliga ayaa ku caawin kara. Adeegani waa lacag la'aan.

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