A plan for life.

Introduction to the Summary of Benefits Report for

CDPHP CHOICE (HMO)
CDPHP VALUE RX (HMO)
CDPHP CHOICE RX (HMO)

January 1, 2014—December 31, 2014
CAPITAL REGION OF NEW YORK STATE

Thank you for your interest in CDPHP Medicare Choices (HMO). Our plan is offered by Capital District Physicians' Health Plan Inc., which is also called CDPHP Medicare Choices, a Medicare Advantage Health Maintenance Organization (HMO) that contracts with the Federal government. This Summary of Benefits tells you some features of our plan. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of our benefits, please call CDPHP Medicare Choices HMO and ask for the "Evidence of Coverage".

YOU HAVE CHOICES IN YOUR HEALTH CARE
As a Medicare beneficiary, you can choose from different Medicare options. One option is the Original (fee-for-service) Medicare Plan. Another option is a Medicare health plan, like CDPHP Medicare Choices (HMO). You may have other options too. You make the choice. No matter what you decide, you are still in the Medicare Program.

You may join or leave a plan only at certain times. Please call CDPHP Medicare Choices (HMO) at the telephone 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 all CDPHP Medicare Choices (HMO) plans to the Original Medicare Plan using this Summary of Benefits. The charts in this booklet list some important health benefits. For each benefit, you can see what our plan covers and what the Original Medicare Plan covers.

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

WHERE ARE CDPHP MEDICARE CHOICES (HMO) PLANS AVAILABLE?
There is more than one plan listed in this Summary of Benefits. The service area for these plans includes: Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington Counties, NY. You must live in one of these areas to join the plan. If you move out of the state or county where you currently live to a state listed above, you must call Customer Service to update your information. If you don't, you may be disenrolled from CDPHP Medicare Choices (HMO). If you move to a state not listed above, please call Customer Service to find out if CDPHP Medicare Choices (HMO) has a plan in your new state or county.

WHO IS ELIGIBLE TO JOIN CDPHP MEDICARE CHOICES (HMO)?
You can join a CDPHP Medicare Choices (HMO) if you are entitled to Medicare Part A and enrolled in Medicare Part B and live in the service area. However, individuals with End-Stage Renal Disease are generally not eligible to enroll in CDPHP Medicare Choices (HMO) unless they are members of our organization and have been since their dialysis began.

CAN I CHOOSE MY DOCTORS?
CDPHP Medicare Choices (HMO) has formed a network of doctors, specialists, and hospitals. You can only use doctors who are part of our network. The health providers in our network can change at any time.

You can ask for a current provider directory. For an updated list, visit us at www.cdphp.com/medicare. Our customer service numbers are listed at the end of this introduction.

Y0019-H3388-14-1010 CMS Accepted

WHAT HAPPENS IF I GO TO A DOCTOR WHO'S NOT IN YOUR NETWORK?
If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither the plan nor the Original Medicare Plan will pay for these services except in limited situations (for example, emergency care).

WHERE CAN I GET MY PRESCRIPTIONS IF I JOIN THIS PLAN?
CDPHP Medicare Choices has formed a network of pharmacies for CDPHP Value Rx (HMO) and CDPHP Choice Rx (HMO), our Medicare HMO plans with prescription drug coverage. 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 http://www.cdphp.com/medicare. Our customer service numbers are listed at the end of this introduction.

WHAT IF MY DOCTOR PRESCRIBES LESS THAN A MONTH'S SUPPLY?
In consultation with your doctor or pharmacist, you may receive less than a month's supply of certain drugs. Also, if you live in a long-term care facility, you will receive less than a month's supply of certain brand and generic drugs. Dispensing fewer drugs at a time can help reduce cost and waste in the Medicare Part D program, when this is medically appropriate.

The amount you pay in these circumstances will depend on whether you are responsible for paying coinsurance (a percentage of the cost of the drug) or a copay (a flat dollar amount for the drug). If you are responsible for coinsurance for the drug, you will continue to pay the applicable percentage of the drug cost. If you are responsible for a copay for the drug, a "daily cost-sharing rate" will be applied. If your doctor decides to continue the drug after a trial period, you should not pay more for a month's supply than you otherwise would have paid. Contact your plan if you have questions about cost-sharing when less than a one-month supply is dispensed.

DOES MY PLAN COVER MEDICARE PART B OR PART D DRUGS?
CDPHP Value Rx (HMO) and CDPHP Choice Rx (HMO) do cover both Medicare Part B and Medicare Part D prescription drugs. CDPHP Choice (HMO) does cover Medicare Part B prescription drugs but does NOT cover Medicare Part D prescription drugs.

WHAT IS A PRESCRIPTION DRUG FORMULARY?
CDPHP Medicare Choices uses a formulary for CDPHP Value Rx (HMO) and CDPHP Choice Rx (HMO), our Medicare HMO plans with prescription drug coverage. 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 http://www.cdphp.com/medicare.

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 CDPHP Medicare Choices (HMO) plans, 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 CDPHP Value Rx (HMO) or CDPHP Choice Rx (HMO), our Medicare HMO plans with prescription drug coverage, 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 to members of CDPHP Value Rx (HMO) or CDPHP Choice Rx (HMO), our Medicare HMO plans with prescription drug coverage. 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 CDPHP Medicare Choices (HMO) for more details.

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

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

—Some Antigens: If they are prepared by a doctor and administered by a properly instructed person (who could be the patient) under doctor supervision.
—Osteoporosis Drugs: Injectable drugs for osteoporosis for some women.
—Erythropoietin: 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 took place in a Medicare-certified facility and was paid for by Medicare or by a private insurance company that was the primary payer for Medicare Part A coverage.
—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 Durable Medical Equipment.

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 can find the Plan Ratings information by using the "Find health & drug plans" web tool on www.medicare.gov 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 on the next page.

Please call CDPHP Medicare Choices for more information about CDPHP Medicare Choices (HMO). Visit us at www.cdphp.com/medicare or, call

Customer Service Hours for October 1 – February 14: Sunday, Monday, Tuesday, Wednesday, Thursday, Friday, Saturday, 8 a.m. - 8 p.m. Eastern

Customer Service Hours for February 15 – September 30: Monday, Tuesday, Wednesday, Thursday, Friday, 8:00 a.m. - 8:00 p.m. Eastern

Current members should call toll-free (888)-248-6522 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-261-1164)

Prospective members should call toll-free (888)-519-4455 for questions related to the Medicare Advantage Program. (TTY/TDD (877)-261-1164)

Current members should call locally (518)-641-3950 for questions related to the Medicare Advantage Program. (TTY/TDD (518)-641-4000)

Prospective members should call locally (518)-641-3400 for questions related to the Medicare Advantage Program. (TTY/TDD (518)-641-4000)

Current members should call toll-free (866)-289-2319 for questions related to the Medicare Part D Prescription Drug Program. (TTY/TDD (866)-236-1069)

Prospective members should call toll-free (888)-519-4455 for questions related to the Medicare Part D Prescription Program. (TTY/TDD (877)-261-1164)

Current members should call locally (518)-641-3950 for questions related to the Medicare Part D Prescription Program. (TTY/TDD (518)-641-4000)

Prospective members should call locally (518)-641-3400 for questions related to Medicare Part D Prescription Drug Program. (TTY/TDD (518)-641-4000)

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 http://www.medicare.gov on the web.

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

If you have any questions about this plan's benefits or costs, please contact CDPHP Medicare Choices (HMO) for details.

IMPORTANT INFORMATION				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
1—Premium and Other Important Information	In 2013, the monthly Part B Premium was $104.90 and may change for 2014 and the annual Part B deductible amount was $147 and may change for 2014. If a doctor or supplier does not accept assignment, their costs are often higher, which means you pay more. Most people will pay the standard monthly Part B premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.	**General** $24 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay a higher premium because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $2,500 out-of-pocket limit. All plan services included. Please see page 29 for more information about the premium and other important information.	**General** $32 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $3,300 out-of-pocket limit. All plan services included. Please see page 29 for more information about the premium and other important information.	**General** $81 monthly plan premium in addition to your monthly Medicare Part B premium. Most people will pay the standard monthly Part B premium in addition to their MA plan premium. However, some people will pay higher Part B and Part D premiums because of their yearly income (over $85,000 for singles, $170,000 for married couples). For more information about Part B and Part D premiums based on income, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may also call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. **In-Network** $2,500 out-of-pocket limit. All plan services included. Please see page 29 for more information about the premium and other important information.
2—Doctor and Hospital Choice (For more information, see Emergency Care–#15, and Urgently Needed Care–#16.)	You may go to any doctor, specialist, or hospital that accepts Medicare.	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).	**In-Network** You must go to network doctors, specialists, and hospitals. Referral required for network hospitals and specialists (for certain benefits).

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
INPATIENT CARE				
3—Inpatient Hospital Care (Includes Substance Abuse and Rehabilitation Services)	In 2013 the amounts for each benefit period were: Days 1 - 60: $1,184 deductible Days 61 - 90: $296 per day Days 91 - 150: $592 per lifetime reserve day These amounts may change for 2014. Call 1-800-MEDICARE (1-800-633-4227) for information about lifetime reserve days. Lifetime reserve days can only be used once. 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.	**In-Network** No limit to the number of days covered by the plan each hospital stay $275 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient hospital care.	**In-Network** No limit to the number of days covered by the plan each hospital stay $550 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient hospital care.	**In-Network** No limit to the number of days covered by the plan each hospital stay $275 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient hospital care.

SUMMARY OF BENEFITS				
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4—Inpatient Mental Health Care	In 2013 the amounts for each benefit period were: Days 1 - 60: $1,184 deductible Days 61 - 90: $296 per day Days 91 - 150: $592 per lifetime reserve day These amounts may change for 2014. 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.	**In-Network** Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. $275 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient mental health care.	**In-Network** Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. $650 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient mental health care.	**In-Network** Contact the plan for details about coverage in a Psychiatric Hospital beyond 190 days. $275 copay for each Medicare-covered hospital stay $0 copay for additional non-Medicare-covered hospital days Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. Please see page 29 for more information about inpatient mental health care.
5—Skilled Nursing Facility (SNF) (in a Medicare-certified skilled nursing facility)	In 2013 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: $148 per day These amounts may change for 2014. 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.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: • Days 1–20: $0 copay per day • Days 21–100: $70 copay per day Please see page 29 for more information about skilled nursing facility care.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: • Days 1–20: $0 copay per day • Days 21–100: $90 copay per day Please see page 29 for more information about skilled nursing facility care.	**General** Authorization rules may apply. **In-Network** Plan covers up to 100 days each benefit period. No prior hospital stay is required. For SNF stays: • Days 1–20: $0 copay per day • Days 21–100: $70 copay per day Please see page 29 for more information about skilled nursing facility care.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
6—Home Health Care (Includes medically necessary intermittent skilled nursing care, home health aide services, and rehabilitation services, etc.)	$0 copay.	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits	**General** Authorization rules may apply. **In-Network** $0 copay for Medicare-covered home health visits
7—Hospice	You pay part of the cost for outpatient drugs and inpatient respite care. You must get care from a Medicare-certified hospice.	**General** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.	**General** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.	**General** You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.
OUTPATIENT CARE				
8—Doctor Office Visits	20% coinsurance	**In-Network** $15 copay for each Medicare-covered primary care doctor visit. $20 copay for each Medicare-covered specialist visit.	**In-Network** $20 copay for each Medicare-covered primary care doctor visit. $30 copay for each Medicare-covered specialist visit.	**In-Network** $15 copay for each Medicare-covered primary care doctor visit. $20 copay for each Medicare-covered specialist visit.
9—Chiropractic Services	Supplemental routine care not covered 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.	**In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).	**In-Network** $20 copay for each Medicare-covered chiropractic visit Medicare-covered chiropractic visits are for manual manipulation of the spine to correct subluxation (a displacement or misalignment of a joint or body part).
10—Podiatry Services	Supplemental routine care not covered. 20% coinsurance for medically necessary foot care, including care for medical conditions affecting the lower limbs.	**In-Network** $20 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.	**In-Network** $30 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.	**In-Network** $20 copay for each Medicare-covered podiatry visit Medicare-covered podiatry visits are for medically-necessary foot care.

SUMMARY OF BENEFITS				
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11—Outpatient Mental Health Care	20% coinsurance for most outpatient mental health services Specified copayment for outpatient partial hospitalization program services furnished by a hospital or community mental health center (CMHC). Copay cannot exceed the Part A inpatient hospital deductible. "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.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $55 for Medicare-covered partial hospitalization program services Please see page 29 for more information about outpatient mental health care.	**General** Authorization rules may apply. **In-Network** $30 copay for each Medicare-covered individual therapy visit $30 copay for each Medicare-covered group therapy visit $30 copay for each Medicare-covered individual therapy visit with a psychiatrist $30 copay for each Medicare-covered group therapy visit with a psychiatrist $55 for Medicare-covered partial hospitalization program services Please see page 29 for more information about outpatient mental health care.	**General** Authorization rules may apply. **In-Network** $20 copay for each Medicare-covered individual therapy visit $20 copay for each Medicare-covered group therapy visit $20 copay for each Medicare-covered individual therapy visit with a psychiatrist $20 copay for each Medicare-covered group therapy visit with a psychiatrist $55 for Medicare-covered partial hospitalization program services Please see page 29 for more information about outpatient mental health care.
12—Outpatient Substance Abuse Care	20% coinsurance	**In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits $20 copay for Medicare-covered group substance abuse outpatient treatment visits	**In-Network** $30 copay for Medicare-covered individual substance abuse outpatient treatment visits $30 copay for Medicare-covered group substance abuse outpatient treatment visits	**In-Network** $20 copay for Medicare-covered individual substance abuse outpatient treatment visits $20 copay for Medicare-covered substance abuse outpatient treatment group visits
13—Outpatient Services	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility services Copay cannot exceed the Part A inpatient hospital deductible. 20% coinsurance for ambulatory surgical center facility services	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit $50 copay for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** $125 copay for each Medicare-covered ambulatory surgical center visit $125 copay for each Medicare-covered outpatient hospital facility visit	**General** Authorization rules may apply. **In-Network** $50 copay for each Medicare-covered ambulatory surgical center visit $50 copay for each Medicare-covered outpatient hospital facility visit

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14—Ambulance Services (Medically necessary ambulance services)	20% coinsurance	**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $100 copay for Medicare-covered ambulance benefits.	**General** Authorization rules may apply. **In-Network** $50 copay for Medicare-covered ambulance benefits.
15—Emergency Care (You may go to any emergency room if you reasonably believe you need emergency care.)	20% coinsurance for the doctor's services Specified copayment for outpatient hospital facility emergency services. Emergency services copay cannot exceed Part A inpatient hospital deductible for each service provided by the hospital. 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. Not covered outside the U.S. except under limited circumstances.	**General** $50 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 24 hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $50 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 24 hour(s) for the same condition, you pay $0 for the emergency room visit.	**General** $50 copay for Medicare-covered emergency room visits Worldwide coverage. If you are admitted to the hospital within 24 hour(s) for the same condition, you pay $0 for the emergency room visit.
16—Urgently Needed Care (This is NOT emergency care and, in most cases, is out of the service area.)	20% coinsurance, or a set copay NOT covered outside the U.S. except under limited circumstances.	**General** $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.	**General** $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24-hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.	**General** $35 copay for Medicare-covered urgently-needed-care visits If you are admitted to the hospital within 24 hour(s) for the same condition, you pay $0 for the urgently-needed-care visit.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
17—Outpatient Rehabilitation Services (Occupational Therapy, Physical Therapy, Speech and Language Therapy)	20% coinsurance Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered.	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $15 copay for Medicare-covered Occupational Therapy visits $15 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $15 copay for Medicare-covered Occupational Therapy visits $15 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits	**General** Authorization rules may apply. Medically necessary physical therapy, occupational therapy, and speech and language pathology services are covered. **In-Network** $15 copay for Medicare-covered Occupational Therapy visits $15 copay for Medicare-covered Physical Therapy and/or Speech and Language Pathology visits
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
18—Durable Medical Equipment (Includes wheelchairs, oxygen, etc.)	20% coinsurance	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment Please see page 29 for more information about durable medical equipment.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment Please see page 29 for more information about durable medical equipment.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered durable medical equipment Please see page 29 for more information about durable medical equipment.
19—Prosthetic Devices (Includes braces, artificial limbs and eyes, etc.)	20% coinsurance 20% coinsurance for Medicare-covered medical supplies related to prosthetics, splints, and other devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices. Please see page 29 for more information about prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices. Please see page 29 for more information about prosthetic devices.	**General** Authorization rules may apply. **In-Network** 20% of the cost for Medicare-covered prosthetic devices 20% of the cost for Medicare-covered medical supplies related to prosthetics, splints, and other devices. Please see page 29 for more information about prosthetic devices.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
20—Diabetes Programs and Supplies	20% coinsurance for diabetes self-management training 20% coinsurance for diabetes supplies 20% coinsurance for diabetic therapeutic shoes or inserts	**In-Network** $0 copay for Medicare-covered Diabetes self-management training 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. Please see page 29 for more information about Diabetes programs and supplies.	**In-Network** $0 copay for Medicare-covered Diabetes self-management training 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. Please see page 29 for more information about Diabetes programs and supplies.	**In-Network** $0 copay for Medicare-covered Diabetes self-management training 20% of the cost for Medicare-covered Diabetes monitoring supplies 20% of the cost for Medicare-covered Therapeutic shoes or inserts Diabetic Supplies and Services are limited to specific manufacturers, products and/or brands. Contact the plan for a list of covered supplies. Please see page 29 for more information about Diabetes programs and supplies.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
21—Diagnostic Tests, X-Rays, Lab Services, and Radiology Services	20% coinsurance for diagnostic tests and X-rays $0 copay for Medicare-covered lab services Lab Services: Medicare covers medically necessary diagnostic lab services that are ordered by your treating doctor when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare. Diagnostic lab services are done to help your doctor diagnose or rule out a suspected illness or condition. Medicare does not cover most supplemental routine screening tests, like checking your cholesterol.	**General** Authorization rules may apply. **In-Network** $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $0 to $20 copay for Medicare-covered X-rays $0 to $20 copay for Medicare-covered diagnostic radiology services (not including X-rays) $20 copay for Medicare-covered therapeutic radiology services Please see page 30 for more information about X-rays, lab services, and radiology services.	**General** Authorization rules may apply. **In-Network** $0 to $30 copay for Medicare-covered lab services $0 to $30 copay for Medicare-covered diagnostic procedures and tests $0 to $30 copay for Medicare-covered X-rays $0 to $30 copay for Medicare-covered diagnostic radiology services (not including X-rays) $30 copay for Medicare-covered therapeutic radiology services Please see page 30 for more information about X-rays, lab services, and radiology services.	**General** Authorization rules may apply. **In-Network** $0 to $20 copay for Medicare-covered lab services $0 to $20 copay for Medicare-covered diagnostic procedures and tests $0 to $20 copay for Medicare-covered X-rays $0 to $20 copay for Medicare-covered diagnostic radiology services (not including X-rays) $20 copay for Medicare-covered therapeutic radiology services Please see page 30 for more information about X-rays, lab services, and radiology services.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
22—Cardiac and Pulmonary Rehabilitation Services	20% coinsurance cardiac rehabilitation services 20% coinsurance for pulmonary rehabilitation services 20% coinsurance for intensive cardiac rehabilitation services	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered Cardiac Rehabilitation Services $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $0 copay for Medicare-covered Pulmonary Rehabilitation Services $10 copay for up to 72 supplemental Intensive Cardiac Rehabilitation Service $0 copay for up to 36 supplemental Pulmonary Rehabilitation Service	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered Cardiac Rehabilitation Services $10 copay for Medicare-covered Intensive Cardiac Rehabilitation Services $0 copay for Medicare-covered Pulmonary Rehabilitation Services $10 copay for up to 72 supplemental Intensive Cardiac Rehabilitation Service $0 copay for up to 36 supplemental Pulmonary Rehabilitation Service	**General** Authorization rules may apply. **In-Network** $10 copay for Medicare-covered Cardiac Rehabilitation Services $10 copay for Medicare-covered Intensive Cardiac Rehabilitation services $0 copay for Medicare-covered Pulmonary Rehabilitation Services $10 copay for up to 72 supplemental Intensive Cardiac Rehabilitation service $0 copay for up to 36 supplemental Pulmonary Rehabilitation Service
PREVENTIVE SERVICES , WELLNESS/EDUCATION AND OTHER SUPPLEMENTAL BENEFIT PROGRAMS				
23—Preventive Services, Wellness/Education and other Supplemental Benefit Programs	No coinsurance, copayment, or deductible for the following: – 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 – 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	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Please see page 30 for more information about preventive services and wellness/education programs.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Please see page 30 for more information about preventive services and wellness/education programs.	**General** $0 copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare mid-year will be covered by the plan or by Original Medicare. Please see page 30 for more information about preventive services and wellness/education programs.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
23— Preventive Services, Wellness/Education and other Supplemental Benefit Programs *(continued)*	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. – 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) tests only. Covered once a year for all men with Medicare over age 50. – Smoking and Tobacco Use Cessation (counseling to stop smoking use). 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. - Screening and behavioral counseling interventions in primary care to reduce alcohol misuse - Screening for depression in adults - Screening for sexually transmitted			

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
23— Preventive Services, Wellness/Education and other Supplemental Benefit Programs *(continued)*	infections (STI) and high-intensity behavioral counseling to prevent STIs - Intensive behavioral counseling for Cardiovascular Disease (bi-annual) - Intensive behavioral therapy for obesity – 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 months.			
24—Kidney Disease and Conditions	20% coinsurance for renal dialysis 20% coinsurance for kidney disease education services	**In-Network** $20 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services Please see page 30 for more information about kidney disease and conditions.	**In-Network** $30 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services Please see page 30 for more information about kidney disease and conditions.	**In-Network** $20 copay for Medicare-covered renal dialysis $0 copay for Medicare-covered kidney disease education services Please see page 30 for more information about kidney disease and conditions.
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** Most drugs not covered. $0 copay for Medicare Part B drugs **Drugs covered under Medicare Part D** **General** This plan does not offer prescription drug coverage.	**Drugs covered under Medicare Part B** **General** $0 copay for Medicare Part B 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 http://www.cdphp.com/medicare on the web.	**Drugs covered under Medicare Part B** **General** $0 copay for Medicare Part B 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 http://www.cdphp.com/medicare on the web.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. 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). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from CDPHP Value Rx (HMO) for certain drugs. 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. 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	Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. 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). Total yearly drug costs are the total drug costs paid by both you and a Part D plan. The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. Some drugs have quantity limits. Your provider must get prior authorization from CDPHP Choice Rx (HMO) for certain drugs. 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. 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

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			the higher cost-sharing amount. If you request a formulary exception for a drug and CDPHP Value Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.	the higher cost-sharing amount. If you request a formulary exception for a drug and CDPHP Choice Rx (HMO) approves the exception, you will pay Tier 4: Non-Preferred Brand Drugs cost sharing for that drug.
			In-Network $0 deductible.	**In-Network** $ 0 deductible.
			Initial Coverage You pay the following until total yearly drug costs reach $2,850:	**Initial Coverage** You pay the following until total yearly drug costs reach $2,850:
			Retail Pharmacy Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier – $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $9 copay for a one-month (30-day) supply of drugs in this tier – $27 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand – $45 copay for a one-month (30-day) supply of drugs in this tier – $135 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $95 copay for a one-month (30-day) supply of drugs in this tier – $285 copay for a three-month (90-day) supply of drugs in this tier	**Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier – $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (30-day) supply of drugs in this tier – $24 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand – $40 copay for a one-month (30-day) supply of drugs in this tier – $120 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $90 copay for a one-month (30-day) supply of drugs in this tier – $270 copay for a three-month (90-day) supply of drugs in this tier

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			Tier 5: Specialty Tier – 33% coinsurance for a one-month (30-day) supply of drugs in this tier	Tier 5: Specialty Tier – 30% coinsurance for a one-month (30-day) supply of drugs in this tier
			Long Term Care Pharmacy Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $9 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand – $45 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $95 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier – 33% coinsurance for a one-month (31-day) supply of drugs in this tier	**Long Term Care Pharmacy** Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (31-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (31-day) supply of drugs in this tier Tier 3: Preferred Brand – $40 copay for a one-month (31-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $90 copay for a one-month (31-day) supply of drugs in this tier Tier 5: Specialty Tier – 30% coinsurance for a one-month (31-day) supply of drugs in this tier

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			Mail Order Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier – $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $9 copay for a one-month (30-day) supply of drugs in this tier – $18 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand – $45 copay for a one-month (30-day) supply of drugs in this tier – $90 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $95 copay for a one-month (30-day) supply of drugs in this tier – $237.50 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier – 33% coinsurance for a one-month (30-day) supply of drugs in this tier	**Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier – $0 copay for a three-month (90-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (30-day) supply of drugs in this tier – $16 copay for a three-month (90-day) supply of drugs in this tier Tier 3: Preferred Brand – $40 copay for a one-month (30-day) supply of drugs in this tier – $80 copay for a three-month (90-day) supply of drugs in this tier Tier 4: Non-Preferred Brand – $90 copay for a one-month (30-day) supply of drugs in this tier – $225 copay for a three-month (90-day) supply of drugs in this tier Tier 5: Specialty Tier – 30% coinsurance for a one-month (30-day) supply of drugs in this tier

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			Coverage Gap After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550.	**Coverage Gap** After your total yearly drug costs reach $2,850, you receive limited coverage by the plan on certain drugs. You will also receive a discount on brand name drugs and generally pay no more than 47.5% for the plan's costs for brand drugs and 72% of the plan's costs for generic drugs until your yearly out-of-pocket drug costs reach $4,550.
				Additional Coverage Gap The plan covers 1,183 formulary generics (66.5% of formulary generic drugs) through the coverage gap. The plan covers formulary brands (0% of formulary brand drugs) through the coverage gap. The plan offers additional coverage in the gap for the following tiers. You pay the following: **Retail Pharmacy** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of all drugs covered in this tier – $0 copay for a three-month (90-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (30-day) supply of all drugs covered in this tier – $24 copay for a three-month (90-day) supply of all drugs covered in this tier

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
				Long Term Care Pharmacy Long term care pharmacies must dispense brand name drugs in amounts less than a 14 days supply at a time. They may also dispense less than a month's supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (31-day) supply of all generic drugs covered in this tier Tier 2: Non-Preferred Generic Drugs – $8 copay for a one-month (31-day) supply of all generic drugs covered in this tier **Mail Order** Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed. Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of all drugs covered in this tier – $0 copay for a three-month (90-day) supply of all drugs covered in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (30-day) supply of all drugs covered in this tier – $16 copay for a three-month (90-day) supply of all drugs covered in this tier

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.	**Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you pay the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs.
			Out-of-Network Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from CDPHP Value Rx (HMO).	**Out-of-Network** Plan drugs may be covered in special circumstances, for instance, illness while traveling outside of the plan's service area where there is no network pharmacy. You may have to pay more than your normal cost-sharing amount if you get your drugs at an out-of-network pharmacy. In addition, you will likely have to pay the pharmacy's full charge for the drug and submit documentation to receive reimbursement from CDPHP Choice Rx (HMO).
			You can get out-of-network drugs the following way: **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $9 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Preferred Brand – $45 copay for a one-month (30-day)	**You can get out-of-network drugs the following way:** **Out-of-Network Initial Coverage** You will be reimbursed up to the plan's cost of the drug minus the following for drugs purchased out-of-network until total yearly drug costs reach $2,850: Tier 1: Preferred Generic – $0 copay for a one-month (30-day) supply of drugs in this tier Tier 2: Non-Preferred Generic – $8 copay for a one-month (30-day) supply of drugs in this tier Tier 3: Preferred Brand – $40 copay for a one-month (30-day)

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
			supply of drugs in this tier Tier 4: Non-Preferred Brand – $95 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier – 33% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.	supply of drugs in this tier Tier 4: Non-Preferred Brand – $90 copay for a one-month (30-day) supply of drugs in this tier Tier 5: Specialty Tier – 30% coinsurance for a one-month (30-day) supply of drugs in this tier You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount.
			Out-of-Network Coverage Gap You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).	**Out-of-Network Coverage Gap** You will be reimbursed up to 28% of the plan allowable cost for generic drugs purchased out-of-network until total yearly out-of-pocket drugs costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s). You will be reimbursed up to 52.5% of the plan allowable cost for brand name drugs purchased out-of-network until your total yearly out-of-pocket drug costs reach $4,550. Please note that the plan allowable cost may be less than the out-of-network pharmacy price paid for your drug(s).
				Additional Out-of-Network Coverage Gap You will be reimbursed for these drugs purchased out-of-network up to the

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
				plan's cost of the drug minus the following: Tier 1: Preferred Generic - $0 copay for a one-month (30-day) supply of all drugs covered within this tier Tier 2: Non-Preferred Generic - $8 copay for a one-month (30-day) supply of all drugs covered in this tier
			Out-of-Network Catastrophic Coverage After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Please see page 30 for more information about outpatient prescription drugs.	**Out-of-Network Catastrophic Coverage** After your yearly out-of-pocket drug costs reach $4,550, you will be reimbursed for drugs purchased out-of-network up to the plan's cost of the drug minus your cost share, which is the greater of: – 5% coinsurance, or – $2.55 copay for generic (including brand drugs treated as generic) and a $6.35 copay for all other drugs. You will not be reimbursed for the difference between the Out-of-Network Pharmacy charge and the plan's In-Network allowable amount. Please see page 30 for more information about outpatient prescription drugs.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
OUTPATIENT MEDICAL SERVICES AND SUPPLIES				
26—Dental Services	Preventive dental services (such as cleaning) not covered.	**In-Network** $0 copay for Medicare-covered dental benefits $0 copay for the following preventive dental benefits: – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 2 fluoride treatment(s) every year – up to 2 dental X-ray(s) every year $250 plan coverage limit for supplemental preventive dental benefits every year Please see page 30 for more information about dental services.	**In-Network** $0 copay for Medicare-covered dental benefits $0 copay for the following preventive dental benefits: – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 2 fluoride treatment(s) every year – up to 2 dental X-ray(s) every year $100 plan coverage limit for supplemental preventive dental benefits every year Please see page 30 for more information about dental services.	**In-Network** $0 copay for Medicare-covered dental benefits $0 copay for the following preventive dental benefits: – up to 2 oral exam(s) every year – up to 2 cleaning(s) every year – up to 2 fluoride treatment(s) every year – up to 2 dental X-ray(s) every year $250 plan coverage limit for supplemental preventive dental benefits every year Please see page 30 for more information about dental services.
27—Hearing Services	Supplemental routine hearing exams and hearing aids not covered. 20% coinsurance for diagnostic hearing exams.	**In-Network** Hearing aids not covered. $20 copay for Medicare-covered diagnostic hearing exams $20 copay for up to 1 supplemental routine hearing exam(s) every year Please see page 30 for more information about hearing services.	**In-Network** Hearing aids not covered. $30 copay for Medicare-covered diagnostic hearing exams $30 copay for up to 1 supplemental routine hearing exam(s) every year Please see page 30 for more information about hearing services.	**In-Network** Hearing aids not covered. $20 copay for Medicare-covered diagnostic hearing exams $20 copay for up to 1 supplemental routine hearing exam(s) every year Please see page 30 for more information about hearing services.

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
28—Vision Services	20% coinsurance for diagnosis and treatment of diseases and conditions of the eye, including an annual glaucoma screening for people at risk. Supplemental routine eye exams and eyeglasses (lenses and frames) not covered. Medicare pays for one pair of eyeglasses or contact lenses after cataract surgery.	**In-Network** $20 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk $0 to $20 copay for up to 1 supplemental routine eye exam(s) every year $0 copay for - eyeglasses (lenses and frames) - contact lenses - eyeglass lenses - eyeglass frames 20% of the cost for one pair of Medicare-Covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $100 plan coverage limit for supplemental eyewear every year. Please see page 30 for more information about vision services.	**In-Network** $30 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 to $30 copay for up to 1 supplemental routine eye exam every year $0 copay for - eyeglasses (lenses and frames) - contact lenses - eyeglass lenses - eyeglass frames 20% of the cost for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $50 plan coverage limit for supplemental eyewear every year. Please see page 30 for more information about vision services.	**In-Network** $20 copay for Medicare-covered exams to diagnose and treat diseases and conditions of the eye, including an annual glaucoma screening for people at risk. $0 to $20 copay for up to 1 supplemental routine eye exam every year $0 copay for - eyeglasses (lenses and frames) - contact lenses - eyeglass lenses - eyeglass frames 20% of the cost for one pair of Medicare-covered eyeglasses (lenses and frames) or contact lenses after cataract surgery. $100 plan coverage limit for supplemental eyewear every year. Please see page 30 for more information about vision services.
Wellness/Education and Other Supplemental Benefits & Services	Not covered.	In-Network The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Additional Smoking and Tobacco Use Cessation Visits - Health Club Membership/Fitness Classes - Nursing Hotline	In-Network The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Additional Smoking and Tobacco Use Cessation Visits - Health Club Membership/Fitness Classes - Nursing Hotline	In-Network The plan covers the following supplemental education/wellness programs: - Health Education - Nutritional Benefit - Additional Smoking and Tobacco Use Cessation Visits - Health Club Membership/Fitness Classes - Nursing Hotline

SUMMARY OF BENEFITS				
Benefit Category	**Original Medicare**	**CDPHP Choice (HMO)**	**CDPHP Value Rx (HMO)**	**CDPHP Choice Rx (HMO)**
Over-the-Counter Items	Not covered.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.	**General** The plan does not cover Over-the-Counter items.
Transportation (Routine)	Not covered.	**General** Authorization rules may apply. **In-Network** $0 copay for each round trip to plan-approved location. Please see page 30 for more information about transportation.	**General** Authorization rules may apply. **In-Network** $0 copay for each round trip to plan-approved location. Please see page 30 for more information about transportation.	**General** Authorization rules may apply. **In-Network** $0 copay for each round trip to plan-approved location. Please see page 30 for more information about transportation.
Acupuncture and Other Alternative Therapies	Not covered.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.	**In-Network** This plan does not cover Acupuncture and other alternative therapies.

FURTHER BENEFIT & SERVICE DESCRIPTIONS

CDPHP offers online enrollment for CDPHP Medicare Choices (HMO) plans. This tool compares the CDPHP Medicare Choices (HMO) plans to help determine the appropriate plan based upon the prospective member's health needs and financial situation. Prospective members can then enroll online in the plan of their choice, quickly and conveniently. CDPHP Medicare sales representatives are available to assist you with a personal consultation. Call (518) 641-3400 or 1-888-519-4455 (TTY/TDD: 1-877-261-1164) or visit www.cdphp.com/medicare for more information.

In most cases, your Primary Care Physician (PCP) must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." Please note, you are required to coordinate your care through your PCP, and your PCP may give you a prescription or note to take with you, but CDPHP does not require a referral number or special form. Be sure to tell the specialist's office staff the name of the PCP who referred you. Your specialist and PCP should be in communication regarding your care. The specialist also should indicate the referring PCP when filing claims for your care.

1. Premium and Other Important Information: The annual out-of-pocket limit does not include your monthly premium.

- For CDPHP Value Rx: The maximum you will pay out-of-pocket in 2014 for all covered medical benefits is $3,300. Once your total copayments/coinsurance in 2014 reaches $3,300, you will receive all covered medical benefits at no cost through December 31, 2014 (unless you leave our plan at an earlier date).
- For CDPHP Choice and CDPHP Choice Rx: The maximum you will pay out-of-pocket in 2014 for all covered medical benefits is $2,500. Once your total copayments/coinsurance in 2014 reaches $2,500, you will receive all covered medical benefits at no cost through December 31, 2014 (unless you leave our plan at an earlier date).

3. Inpatient Hospital Care: You may be admitted to the hospital multiple times from January 1, 2014, through December 31, 2014.

4. Inpatient Mental Health Care: The 190-day limit may not apply to mental health care service provided in a psychiatric unit of a general hospital. You may be admitted to the hospital multiple times from January 1, 2014, through December 31, 2014.

5. Skilled Nursing Facility: You are covered for 100 days of skilled nursing facility care after a medical event, such as a hospital stay or outpatient surgery. Custodial and long-term care services are not covered.

11. Outpatient Mental Health Care: Your partial hospitalization copayment may include multiple visits, depending upon the kind of treatment. Please contact the Behavioral Health Access Center at 1-888-320-9584 or (518) 641-3600 for more information.

18. Durable Medical Equipment: Prior authorization is required for all rentals and for purchases of each covered item totaling $500 or more.

- For CDPHP Value Rx: You pay 20% of the Medicare-allowed fee, up to a maximum of $250, for each Medicare-covered item.
- For CDPHP Choice and CDPHP Choice Rx: You pay 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered item.

19. Prosthetic Devices: All colostomy supplies are covered in full. Prior authorization is required for all rentals and for purchases of each covered item totaling $500 or more.

- For CDPHP Value Rx: You pay 20% of the Medicare-allowed fee, up to a maximum of $250, for each Medicare-covered item.
- For CDPHP Choice and CDPHP Choice Rx: You pay 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered item.

20. Diabetes Programs and Supplies: Diabetic monitoring items, glucose-control solutions, test strips, and lancets do not apply to your outpatient prescription drug limit, but they do count toward your annual out-of-pocket limit. You pay the following:

- For all plans: No copayment for blood glucose monitors (limited to 1 per year) and blood glucose test strips (limited to a 30-day supply) made by Bayer Diabetes Care; if you use a monitor or test strips made by a different manufacturer, contact member services for more information or to request an exception.
- For all plans: $10 or 20% of the Medicare-allowed fee (whichever is less) for up to a 30-day supply of each diabetes supply covered under Part B (including lancets, glucose control solutions, insulin pump supplies, reservoirs, etc.)
- For CDPHP Value Rx: 20% of the Medicare-allowed fee, up to a maximum of $250, for each Medicare-covered diabetic monitoring supply or durable medical equipment item covered under Part B (including insulin pumps, therapeutic custom-molded shoes and inserts (one pair per calendar year), etc.).

- For CDPHP Choice and CDPHP Choice Rx: 20% of the Medicare-allowed fee, up to a maximum of $200, for each Medicare-covered diabetic monitoring supply or durable medical equipment item covered under Part B (including insulin pumps, therapeutic custom-molded shoes and inserts (one pair per calendar year), etc.).

21. **X-Rays, Lab Services, and Radiology Services:** Copayment is waived for X-Rays, Lab Services and Radiology Services performed by a CDPHP Preferred Laboratory, X-Ray or Radiology Network Provider. A listing of Preferred Laboratory, X-Ray or Radiology Network Providers will be provided upon request and are available at www.cdphp.com/findadoc, or by using the Find-A-Doc Mobile app for iPhone, Blackberry, or Android.

23. **Preventive Services and Wellness/Education Programs:**
    - **Cervical and Vaginal Cancer Screening:** Covered once every 2 years. Covered once a year for women with Medicare at high risk.
    - **Colorectal Cancer Screening:** Covered for all members with Medicare over age 50. Screenings exams can include any one or more of the following services: Colonoscopy, Flexible Sigmoidoscopy, Fecal Occult Blood screening, or Barium Enema. Please consult with your provider to determine the best place for you to receive these services.
      - When any of these screening services are performed in a physician's office, you do not pay a copayment, but there may be a copayment for other services performed during that office visit.
      - When any of these screening services are performed in a freestanding ambulatory surgery facility or in the outpatient department of a hospital, no copayment applies.
      - For non-screening exams or diagnostic procedures for acute conditions, an outpatient or office visit copayment will apply.
      - If a diagnosis is made during a screening exam, that exam will require a copayment. You can only be charged one copayment per provider per day. Refer to 13 – Outpatient Services/Surgery on page 30 for more information.
    - **Supplemental Education/Wellness Programs:** CDPHP covers a variety of services designed to help keep you healthy. Call the CDPHP wellness line at (518) 641-4800 for more details. Programs include, but are not limited to:
      - No-cost review of your medical needs and 24/7 access to medical experts and health information through our Health Coach Connection℠ and Health Ally℠ programs.
      - No-cost health club memberships/fitness classes are limited to the Senior Fit® network, which includes The Beltrone Living Center, Rudy A. Cicotti Center, Sunnyview Lifestyle Wellness Hospital and participating Capital District and Glens Falls YMCAs, SilverSneakers®, and Curves® locations.

24. **Kidney Disease and Conditions:** Out-of-area renal dialysis services are only covered within the U.S. The U.S. includes the 50 states, District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

25. **Outpatient Prescription Drugs – Drugs Covered Under Medicare Part D:** CDPHP, through its pharmacy benefits manager, Caremark Part D Services, LLC, has a network of more than 65,800 pharmacies across the U.S. You can find a pharmacy when you are outside our service area by calling 1-866-289-2319 (TTY/TDD: 1-866-236-1069), visiting www.cdphp.com/findadoc, or using the Find-A-Doc Mobile app for iPhone, Blackberry, or Android.

26. **Dental Services:** Preventive Dental Services benefit can be used at any dental provider in or out-of-network. No referral is necessary. **Periodontal cleanings are not covered**. You must pay for all covered supplemental dental services first, then submit your itemized receipt to CDPHP for applicable reimbursement by mailing to: CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206.

27. **Hearing Services:** No referral necessary for hearing exams at network providers.

28. **Vision Services:** You have a $0 copayment for annual glaucoma screenings. You pay 20% of the Medicare-allowed fee schedule for eye glasses (lenses and frames) or contact lenses after cataract surgery. Medicare-covered eyewear for medical purposes will be administered under the durable medical equipment and/or prosthetic devices section of the contract. All eyewear can be obtained at any optical vendor in-or-out-of-network. No referral necessary for eye exams at network providers.
    - For CDPHP Choice and CDPHP Choice Rx: You must pay for all supplemental routine eyewear first, then submit your itemized receipt to CDPHP for applicable reimbursement by mailing to: CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206.

Transportation (Routine): If you need non-emergency transportation to a provider's office or facility within the plan's service area, CDPHP may be able to help. Transportation for medical services must be pre-approved by the plan prior to the transportation being rendered. Any routine transportation not pre-approved by the plan will not be covered. Routine medical transportation is covered only when you are enrolled in the Plan's case management services and any other means of transportation would endanger your health. For details, contact the Resource Coordination department at 1-800-274-2332.