CDPHP Medicare Choices ~ Group HMO Plan Options
Effective January 1, 2010

Type of Medical Service	CDPHP Group Medicare Choice $10	CDPHP Group Medicare Choice $12	CDPHP Group Medicare Choice $15	CDPHP Group Medicare Choice $20	CDPHP Group Medicare Choice $25	CDPHP Group Medicare Choice $25/$40	CDPHP Group Medicare Choice $30/$50	CDPHP Group Medicare Choice $50
Primary Care Physician Visits	$10	$12	$15	$20	$25	$25	$30	$50
Specialty Visits	$10	$12	$15	$20	$25	$40	$50	$50
Annual Out-of-Pocket Maximum (Member Responsibility)	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500	$2,500
Routine Annual Adult Exam	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Physician Services During Inpatient Stay	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Bone Mass Screening	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Mammograms	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Pap smears and pelvic exams	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Colorectal Screening Exams	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Prostate Cancer Screening	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Immunizations (Flu, Pneumonia & Hepatitis B)	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Inpatient Hospitalization	No copayment	$250 (Max 3 copays per year)	No copayment	$250 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)
Outpatient Surgery	No copayment	$100	$50	$100	$125	$100	$125	$125
Lab Services	No copayment	$12	$15	$20	$25	$40	$50	$50
X-Rays	No copayment	$12	$15	$20	$25	$40	$50	$50
Emergency Care	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)	$50 (waived if admitted)
Ambulance Services	$35	$50	$35	$50	$100	$100	$100	$100
Urgent Care	$10	$12 - $35	$15 - $35	$20 - $35	$25 - $35	$25 - $40	$30 - $50	$50
Physical, Speech & Occupational Therapies	$10	$12	$15	$20	$25	$40	$50	$50
Chiropractic Care	$10	$12	$15	$20	$25	$40	$50	$50
Home Health Care	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Prosthetic Devices	20% - $200 max out-of-pocket cost per item	20% - $200 max out-of-pocket cost per item	15% - $200 max out-of-pocket cost per item	20% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item
DME	20% - $200 max out-of-pocket cost per item	20% - $200 max out-of-pocket cost per item	15% - $200 max out-of-pocket cost per item	20% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item	30% - $200 max out-of-pocket cost per item
Diabetic Insulin, Needles & Syringes	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit	Covered under Part D benefit
Diabetic Supplies	20% coinsurance or $10 copay, whichever is less	20% coinsurance or $10 copay, whichever is less	15% coinsurance or $10 copay, whichever is less	20% coinsurance or $10 copay, whichever is less	30% coinsurance or $10 copay, whichever is less	30% coinsurance or $10 copay, whichever is less	30% coinsurance or $10 copay, whichever is less	30% coinsurance or $10 copay, whichever is less
Diabetic DME	20% coinsurance	20% coinsurance	15% coinsurance	20% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance
Inpatient Mental Health	No copayment (190-day lifetime limit)	$250 (190-day lifetime limit) (Max 3 copays per year)	No copayment (190-day lifetime limit)	$250 (190-day lifetime limit) (Max 3 copays per year)	$500 (190-day lifetime limit) (Max 3 copays per year)	$500 (190-day lifetime limit) (Max 3 copays per year)	$500 (190-day lifetime limit) (Max 3 copays per year)	$500 (190-day lifetime limit) (Max 3 copays per year)
Outpatient Mental Health	$10 Ind visits $10 Grp visits	$12 Ind visits $12 Grp visits	$15 Ind visits $15 Grp visits	$20 Ind visits $20 Grp visits	$25 Ind. Visits $25 Grp. Visits	$40 Ind. Visits $40 Grp. Visits	$50 Ind. Visits $50 Grp. Visits	$50 Ind. Visits $50 Grp. Visits
Inpatient Substance Abuse	No copayment	$250 (Max 3 copays per year)	No copayment	$250 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)	$500 (Max 3 copays per year)
Outpatient Substance Abuse	$10 Ind visits $10 Grp visits	$12 Ind visits $12 Grp visits	$15 Ind visits $15 Grp visits	$20 Ind visits $20 Grp visits	$25 Ind. Visits $25 Grp. Visits	$40 Ind. Visits $40 Grp. Visits	$50 Ind. Visits $50 Grp. Visits	$50 Ind. Visits $50 Grp. Visits
Skilled Nursing Facility	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment	No copayment
Hearing Services	$10 exam $600 allowance every 3 years for hearing aids	$12 exam $600 allowance every 3 years for hearing aids	$15 exam $600 allowance every 3 years for hearing aids	$20 exam $600 allowance every 3 years for hearing aids	$25 exam $600 allowance every 3 years for hearing aids	$40 exam $600 every 3 years hearing aid allowance	$50 exam $600 every 3 years hearing aid allowance	$50 exam $600 every 3 years hearing aid allowance
Vision Services	$10 exam $80 eyewear allowance every 12 months	$12 exam $80 eyewear allowance every 12 months	$15 exam $80 eyewear allowance every 12 months	$20 exam $80 eyewear allowance every 12 months	$25 exam $80 eyewear allowance every 12 months	$40 exam $80 eyewear allowance every 12 months	$50 exam $80 eyewear allowance every 12 months	$50 exam $80 eyewear allowance every 12 months
Dental Services	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year	Preventative Dental - $150 annual reimbursement for dental office visits and cleanings up to 2 per year
Health/Wellness Education	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes	SilverSneakers/ Curves/ Capital District YMCAs/ Health Wellness Classes

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Travel	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually	30% up to $3,000 annually