CDPHP® Medicare Advantage HMO

SUMMARY OF BENEFITS

HMO

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CDPHP® Medicare Advantage

CDPHP $0 Medicare Rx (HMO)
CDPHP Basic Rx (HMO)
CDPHP Value Rx (HMO)
CDPHP Choice (HMO)
CDPHP Choice Rx (HMO)

2021 Summary of Benefits

January 1, 2021–December 31, 2021
CAPITAL REGION OF NEW YORK STATE

Our service area includes these counties in New York State: Albany, Broome, Chenango, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Warren, and Washington.

Learn more about CDPHP Medicare Advantage plans, including health and prescription drug benefits, with this guide.

This information is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To receive a complete list of services we cover, call us and ask for the "Evidence of Coverage."

CDPHP is an HMO with a Medicare Contract. Enrollment in CDPHP Medicare Advantage depends on contract renewal.

Who can join?

To be eligible to join a CDPHP Medicare Advantage plan—CDPHP $0 Medicare Rx (HMO), CDPHP Basic Rx (HMO), CDPHP Value Rx (HMO), CDPHP Choice (HMO), or CDPHP Choice Rx (HMO)—you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

To access or order the "Medicare & You" handbook from CMS, visit www.medicare.gov/medicare-and-you.

How can I contact CDPHP?

If you are already a member of a CDPHP Medicare Advantage plan, call toll-free 1-888-248-6522 (TTY: 711).

If you are not already a member of a CDPHP Medicare Advantage plan, call toll-free 1-888-519-4455 (TTY: 711).

You can also visit our website: http://www.cdphp.com/medicare.

When can I contact you?

October 1–March 31: Call us seven days a week from 8 a.m. to 8 p.m.

April 1–September 30: Call us Monday through Friday from 8 a.m. to 8 p.m.

A voice messaging service is used on weekends, after hours, and federal holidays. Calls will be returned within one business day.

Which doctors, hospitals, and pharmacies can I use?

CDPHP Medicare Advantage plans – CDPHP $0 Medicare Rx (HMO), CDPHP Basic Rx (HMO), CDPHP Value Rx (HMO), CDPHP Choice (HMO), and CDPHP Choice Rx (HMO) has a network of doctors, hospitals, pharmacies and other providers. If you use providers who are not in our network, the plan may not pay for these services. Find network providers online at findadoc.cdphp.com.

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Monthly Premium	$0.00 per month. You must keep paying your Medicare Part B premium.	$31.00 per month. You must keep paying your Medicare Part B premium.
Deductible	This plan does not have a deductible.	This plan does not have a deductible.
Maximum Out of Pocket Responsibility (does not include prescription drugs)	• $7,500 for services you receive from in-network providers.	• $6,700 for services you receive from in-network providers.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
$60.80 per month. You must keep paying your Medicare Part B premium.	$39.90 per month. You must keep paying your Medicare Part B premium.	$130.00 per month. You must keep paying your Medicare Part B premium.
This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
• $5,800 for services you receive from in-network providers.	• $5,000 for services you receive from in-network providers.	• $5,000 for services you receive from in-network providers.

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
COVERED MEDICAL BENEFITS		
Note: **• Services with a [1] may require prior authorization.** **• Services with a [2] may require a referral from your doctor.**		
Inpatient Hospital Care	• $360 Copay per day for days 1 through 5 • You pay nothing per day for days 6 and beyond	• $335 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond
Outpatient Hospital Coverage	$365 Copay for observation. $365 Copay for outpatient surgery billed by a hospital.	$330 Copay for observation. $330 Copay for outpatient surgery billed by a hospital.
Ambulatory Surgery Center	$315 Copay for surgery at a freestanding ambulatory surgery center.	$280 Copay for surgery at a freestanding ambulatory surgery center.
Doctor's Office Visits	Primary care physician visit: $0 Copay Specialist visit: $50 Copay	Primary care physician visit: $0 Copay Specialist visit: $45 Copay
Preventive Care	You pay nothing for Medicare approved preventive services	You pay nothing for Medicare approved preventive services
Emergency Care	$90 Copay (waived if admitted)	$90 Copay (waived if admitted)
Urgently Needed Services	$65 Copay	$65 Copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these services may be different if received in an outpatient hospital setting)***	Diagnostic radiology services (as MRIs, CT scans): $195 Copay Diagnostic tests and procedures: 20% Coinsurance Lab services: 0–20% Coinsurance Outpatient X-rays: $50 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost $0 Copay at preferred laboratory for Outpatient and diagnostic laboratory services	Diagnostic radiology services (such as MRIs, CT scans): $140 Copay Diagnostic tests and procedures: $45 Copay Lab services: $0–45 Copay Outpatient X-rays: $40 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost $0 Copay at preferred laboratory for Outpatient and diagnostic laboratory services
Hearing Services	Routine hearing exam: $50 Copay $599 Copay for covered advanced plus hearing aid purchases per year $899 copay for covered Premium hearing aid purchase per year	Routine hearing exam: $45 Copay $599 Copay for covered advanced plus hearing aid purchases per year $899 copay for covered Premium hearing aid purchase per year

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
COVERED MEDICAL BENEFITS		
Note: **• Services with a [1] may require prior authorization.** **• Services with a [2] may require a referral from your doctor.**		
• $295 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond	• $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond	• $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond
$300 Copay for observation $300 Copay for outpatient surgery billed by a hospital.	$200 Copay for observation $200 Copay for outpatient surgery billed by a hospital.	$200 Copay for observation $200 Copay for outpatient surgery billed by a hospital.
$200 Copay for surgery at a freestanding ambulatory surgery center.	$150 Copay for surgery at a freestanding ambulatory surgery center.	$150 Copay for surgery at a freestanding ambulatory surgery center.
Primary care physician visit: $0 Copay Specialist visit: $35 Copay	Primary care physician visit: $0 Copay Specialist visit: $30 Copay	Primary care physician visit: $0 Copay Specialist visit: $30 Copay
You pay nothing for Medicare approved preventive services	You pay nothing for Medicare approved preventive services	You pay nothing for Medicare approved preventive services
$90 Copay (waived if admitted)	$90 Copay (waived if admitted)	$90 Copay (waived if admitted)
$60 Copay	$55 Copay	$55 Copay
Diagnostic radiology services (such as MRIs, CT scans): $130 Copay Diagnostic tests and procedures: $35 Copay Lab services: $0–35 Copay Outpatient X-rays: $35 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost $0 Copay at preferred laboratory for Outpatient and diagnostic laboratory services	Diagnostic radiology services (such as MRIs, CT scans): $100 Copay Diagnostic tests and procedures: $30 Copay Lab services: $0–30 Copay Outpatient X-rays: $30 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost $0 Copay at preferred laboratory for Outpatient and diagnostic laboratory services	Diagnostic radiology services (such as MRIs, CT scans): $100 Copay Diagnostic tests and procedures: $30 Copay Lab services: $0–30 Copay Outpatient X-rays: $30 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost $0 copayment at preferred laboratory Copay Outpatient and diagnostic laboratory services
Routine hearing exam: $35 Copay $599 Copay for covered advanced plus hearing aid purchases per year $899 copay for covered Premium hearing aid purchase per year	Routine hearing exam: $30 Copay $199 Copay for covered advanced plus hearing aid purchases per year $499 copay for covered Premium hearing aid purchase per year	Routine hearing exam: $30 Copay $199 Copay for covered advanced plus hearing aid purchases per year $499 copay for covered Premium hearing aid purchase per year

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Dental Services	Preventive Dental services from a Delta Dental for CDPHP Medicare Advantage participating provider in your dental plan network. Preventive Dental services include cleanings. Limitations: • Oral exams are limited to one per calendar year. • Routine cleanings are limited to one per calendar year. • X-rays are limited to one per calendar year. $20 Copay for each routine preventive dental exam at participating providers in Delta Dental's network for CDPHP Medicare Advantage plans. $50 Copay for Medicare-covered non-routine dental services. $20 for each covered bitewing X-ray $30 for each covered panoramic X-ray $30 for each covered full-mouth X-ray Delta Dental Restorative Services (Non-Medicare covered comprehensive coverage) $60-$595 copayment per covered restorative service (including crowns and fillings) If you visit a dentist that is not in our dental network, you will be responsible for 100% of the cost. For a full list of limits and exclusions please visit Delta Dental's website at http://www.deltadentalins.com/CDPHPMedicare or call Delta Dental's Customer Service Center toll-free at 1-800-592-0132.	Preventive Dental services from a Delta Dental for CDPHP Medicare Advantage participating provider in your dental plan network. Preventive Dental services include cleanings. Limitations: • Oral exams are limited to two per calendar year. • Routine cleanings are limited to two per calendar year. • X-rays are limited to twice per calendar year. $20 Copay for each routine preventive dental exam at participating providers in Delta Dental's network for CDPHP Medicare Advantage plans. $45 Copay for Medicare-covered non-routine dental services. $20 for each covered bitewing X-ray $30 for each covered panoramic X-ray $30 for each covered full-mouth X-ray Delta Dental Restorative Services (Non-Medicare covered comprehensive coverage) $60-$595 copayment per covered restorative service (including crowns and fillings) If you visit a dentist that is not in our dental network, you will be responsible for 100% of the cost. For a full list of limits and exclusions please visit Delta Dental's website at http://www.deltadentalins.com/CDPHPMedicare or call Delta Dental's Customer Service Center toll-free at 1-800-592-0132.
Vision Services	Routine eye exam: $20 Copay Our plan pays up to $75 every two years for eyewear.	Routine eye exam: $20 Copay Our plan pays up to $75 every year for eyewear.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Preventive Dental services from a Delta Dental for CDPHP Medicare Advantage participating provider in your dental plan network. Preventive Dental services include cleanings. Limitations: • Oral exams are limited to two per calendar year. • Routine cleanings are limited to two per calendar year. • X-rays are limited to twice per calendar year. $10 Copay for each routine preventive dental exam at participating providers in Delta Dental's network for CDPHP Medicare Advantage plans. $35 Copay for Medicare-covered non-routine dental services. $10 for each covered bitewing X-ray $15 for each covered panoramic X-ray $15 for each covered full-mouth X-ray Delta Dental Restorative Services (Non-Medicare covered comprehensive coverage) $60-$595 copayment per covered restorative service (including crowns and fillings) If you visit a dentist that is not in our dental network, you will be responsible for 100% of the cost. For a full list of limits and exclusions please visit Delta Dental's website at http://www.deltadentalins.com/CDPHPMedicare or call Delta Dental's Customer Service Center toll-free at 1-800-592-0132.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $30 Copay for Medicare covered non-routine dental services Our plan pays for 2 preventive dental services every year. This includes 2 oral exams, 2 cleanings, and 2 sets of dental X-rays. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not considered routine and are excluded from coverage.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $30 Copay for Medicare covered non-routine dental services Our plan pays for 2 preventive dental services every year. This includes 2 oral exams, 2 cleanings, amd 2 sets of dental X-rays. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not considered routine and are excluded from coverage.
Routine eye exam: $20 Copay Our plan pays up to $100 every year for eyewear.	Routine eye exam: $0 Copay Our plan pays up to $125 every year for eyewear.	Routine eye exam: $0 Copay Our plan pays up to $125 every year for eyewear.

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Mental Health Care	Inpatient visit: • $330 Copay per day for days 1 through 5 • You pay nothing per day for days 6 and beyond Outpatient group therapy visit: $40 Copay Outpatient individual therapy visit: $40 Copay	Inpatient visit: • $315 Copay per day for days 1 through 5 • You pay nothing per day for days 6 and beyond Outpatient group therapy visit: $40 Copay Outpatient individual therapy visit: $40 Copay
Skilled Nursing Facility (SNF) [1]	• You pay nothing per day for days 1 through 20 • $184 Copay per day for days 21 through 100 Prior Authorization required	• You pay nothing per day for days 1 through 20 • $150 Copay per day for days 21 through 100 Prior Authorization required
Physical Therapy, Occupational Therapy, and Speech Therapy	Occupational therapy visit: $40 Copay Physical therapy and speech and language therapy visit: $40 Copay	Occupational therapy visit: $40 Copay Physical therapy and speech and language therapy visit: $40 Copay
Ambulance [1]	$265 Copay Prior Authorization required for Air Ambulance only	$260 Copay Prior Authorization required for Air Ambulance only
Transportation [1]	Not covered Non-emergent and/or routine transportation requests may be available when deemed medically necessary and/or appropriate by CDPHP Case Management staff. Services not authorized in advance by CDPHP will not be covered.	Not covered Non-emergent and/or routine transportation requests may be available when deemed medically necessary and/or appropriate by CDPHP Case Management staff. Services not authorized in advance by CDPHP will not be covered.
Medicare Part B Drugs [1]	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Inpatient visit: • $275 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond Outpatient group therapy visit: $35 Copay Outpatient individual therapy visit: $35 Copay	Inpatient visit: • $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond Outpatient group therapy visit: $30 Copay Outpatient individual therapy visit: $30 Copay	Inpatient visit: • $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 and beyond Outpatient group therapy visit: $30 Copay Outpatient individual therapy visit: $30 Copay
• You pay nothing per day for days 1 through 20 • $140 Copay per day for days 21 through 100 Prior Authorization required	• You pay nothing per day for days 1 through 20 • $120 Copay per day for days 21 through 100 Prior Authorization required	• You pay nothing per day for days 1 through 20 • $120 Copay per day for days 21 through 100 Prior Authorization required
Occupational therapy visit: $35 Copay Physical therapy and speech and language therapy visit: $35 Copay	Occupational therapy visit: $30 Copay Physical therapy and speech and language therapy visit: $30 Copay	Occupational therapy visit: $30 Copay Physical therapy and speech and language therapy visit: $30 Copay
$250 Copay Prior Authorization required for Air Ambulance only	$165 Copay Prior Authorization required for Air Ambulance only	$165 Copay Prior Authorization required for Air Ambulance only
Not covered Non-emergent and/or routine transportation requests may be available when deemed medically necessary and/or appropriate by CDPHP Case Management staff. Services not authorized in advance by CDPHP will not be covered.	Not covered Non-emergent and/or routine transportation requests may be available when deemed medically necessary and/or appropriate by CDPHP Case Management staff. Services not authorized in advance by CDPHP will not be covered.	Not covered Non-emergent and/or routine transportation requests may be available when deemed medically necessary and/or appropriate by CDPHP Case Management staff. Services not authorized in advance by CDPHP will not be covered.
20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs	20% of the cost for chemotherapy drugs 20% of the cost for other Part B drugs

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
PRESCRIPTION DRUG BENEFITS		
Deductible	$300 Medicare-defined Part D deductible. This deductible applies to Tiers 3 through 5.	This plan does not have an Rx deductible.

Phase 1: Initial Coverage
You pay the following until your total yearly drug costs reach $4,130. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.

You may get your drugs at network retail pharmacies and mail order pharmacies.

Tier	$0 Medicare Rx (HMO) One Month Supply	$0 Medicare Rx (HMO) Three Month Supply	Basic Rx (HMO) One Month Supply	Basic Rx (HMO) Three Month Supply
Tier 1 (Preferred Generic)	$3 Copay	$9 Copay	$3 Copay	$9 Copay
Tier 2 (Generic)	$17 Copay	$51 Copay	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$47 Copay	$141 Copay	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay	$97 Copay	$291 Copay
Tier 5 (Specialty Tier)	27% of the cost	Not Offered	33% of the cost	Not Offered

<table>
<tr><th>CDPHP Value Rx (HMO)</th><th>CDPHP Choice (HMO)</th><th>CDPHP Choice Rx (HMO)</th></tr>
<tr><td colspan="3">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>This plan does not have an Rx deductible.</td><td>This plan does not cover Part D prescription drugs.</td><td>This plan does not have an Rx deductible.</td></tr>
<tr><td>
<table>
<tr><th>Tier</th><th>One Month Supply</th><th>Three Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$2 Copay</td><td>$6 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$13 Copay</td><td>$39 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$42 Copay</td><td>$126 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$93 Copay</td><td>$279 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr>
</table>
</td><td>This plan does not cover Part D prescription drug.</td><td>
<table>
<tr><th>Tier</th><th>One Month Supply</th><th>Three Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$11 Copay</td><td>$33 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$40 Copay</td><td>$120 Copay</td></tr>
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</table>
</td></tr>
</table>

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)			Basic Rx (HMO)		
Preferred Mail Order Cost-Sharing	Tier	**One Month Supply**	**Three Month Supply**	Tier	**One Month Supply**	**Three Month Supply**
	Tier 1 (Preferred Generic)	$3 Copay	$0 Copay	Tier 1 (Preferred Generic)	$3 Copay	$0 Copay
	Tier 2 (Generic)	$17 Copay	$34 Copay	Tier 2 (Generic)	$15 Copay	$30 Copay
	Tier 3 (Preferred Brand)	$47 Copay	$94 Copay	Tier 3 (Preferred Brand)	$45 Copay	$90 Copay
	Tier 4 (Non-Preferred Drug)	$100 Copay	$250 Copay	Tier 4 (Non-Preferred Drug)	$97 Copay	$242.50 Copay
	Tier 5 (Specialty Tier)	27% of the cost	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.		
Non-Preferred Mail Order Cost-Sharing	Tier	**One Month Supply**	**Three Month Supply**	Tier	**One Month Supply**	**Three Month Supply**
	Tier 1 (Preferred Generic)	$3 Copay	$9 Copay	Tier 1 (Preferred Generic)	$3 Copay	$9 Copay
	Tier 2 (Generic)	$17 Copay	$51 Copay	Tier 2 (Generic)	$15 Copay	$45 Copay
	Tier 3 (Preferred Brand)	$47 Copay	$141 Copay	Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
	Tier 4 (Non-Preferred Drug)	$100 Copay	$300 Copay	Tier 4 (Non-Preferred Drug)	$97 Copay	$291 Copay
	Tier 5 (Specialty Tier)	27% of the cost	Not Covered	Tier 5 (Specialty Tier)	33% of the cost	Not Covered
	If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.			If you reside in a long-term care facility, you pay the same as at a retail pharmacy. You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.		

CDPHP Value Rx (HMO)

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$2 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$26 Copay
Tier 3 (Preferred Brand)	$42 Copay	$84 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay	$232.50 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$2 Copay	$6 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay	$279 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Covered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

CDPHP Choice (HMO)

CDPHP Choice Rx (HMO)

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$11 Copay	$22 Copay
Tier 3 (Preferred Brand)	$40 Copay	$80 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$225 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$11 Copay	$33 Copay
Tier 3 (Preferred Brand)	$40 Copay	$120 Copay
Tier 4 (Non-Preferred Drug)	$90 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Covered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Coverage Gap	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. 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 $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.	Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. 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 $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • 5% of the cost, or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 Copay for all other drugs.	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • 5% of the cost, or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 Copay for all other drugs.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. 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 $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.		Most Medicare drug plans have a coverage gap (also called the “donut hole”). This means that there’s a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $4,130. 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 $6,550, which is the end of the coverage gap. Not everyone will enter the coverage gap.
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • 5% of the cost, or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 Copay for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $6,550, you pay the greater of: • 5% of the cost, or • $3.70 Copay for generic (including brand drugs treated as generic) and a $9.20 Copay for all other drugs.

Summary of Benefits January 1, 2021–December 31, 2021

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
ADDITIONAL COVERED MEDICAL BENEFITS		
Chiropractic Care	$20 Copay	$20 Copay
Foot Care ***(podiatry services)***	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $50 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $45 Copay
Home Health Care	You pay nothing.	You pay nothing.
Medical Equipment/Supplies [1]	20% of the cost Prior authorization is required for all rentals. Prior authorization is also required for purchases or repairs of each covered items totaling $1,000 or more. Blood glucose test strips: no Copay (limited to a 90 day supply from Ascensia Diabetes Care). Blood glucose monitor: no Copay (limited to one per year from Ascensia Diabetes Care). All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (90 day supply). Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost	20% of the cost Prior authorization is required for all rentals. Prior authorization is also required for purchases or repairs of each covered items totaling $1,000 or more. Blood glucose test strips: no Copay (limited to a 90 day supply). Ascensia Diabetes Care). Blood glucose monitor: no Copay (limited to one per year from Ascensia Diabetes Care). All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (90 day supply). Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost
Dialysis	20% of the cost Out-of-area dialysis services are covered only within the United States.	20% of the cost Out-of-area dialysis services are covered only within the United States.
Telemedicine Visit	Doctor On Demand Visit: $0 Copay	Doctor On Demand Visit: $0 Copay
Wellness Programs Senior Fit—Enjoy no-cost access to dozens of area gyms and fitness facilities. LifePoints and CaféWell—Earn up to $175 in LifePoints through CaféWell.	Covered	Covered
Telenutrition Services (Zipongo)	$0 Copay	$0 Copay
Acupuncture 10 visits for any condition 12 visits for diagnosis of chronic low back pain	50% of the Medicare allowed amount	50% of the Medicare allowed amount
Over-the-Counter (OTC) Items	$50/Every 3 months	$50/Every 3 months
Inpatient post-discharge meal benefit	Covered	Covered
In-home Palliative Medical Care	Covered	Covered

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
ADDITIONAL COVERED MEDICAL BENEFITS		
$20 Copay	$20 Copay	$20 Copay
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $30 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $30 Copay
You pay nothing.	You pay nothing.	You pay nothing.
You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all rentals. Prior authorization is also required for purchases or repairs of each covered items totaling $1,000 or more. Blood glucose test strips: no Copay (limited to a 90 day supply from Ascensia Diabetes Care). Blood glucose monitor: no Copay (limited to one per year from Ascensia Diabetes Care). All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (90 day supply). Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost	You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all rentals. Prior authorization is also required for purchases or repairs of each covered items totaling $1,000 or more. Blood glucose test strips: Copay (limited to a 90 day supply from Ascensia Diabetes Care). Blood glucose monitor: no Copay (limited to one per year from Ascensia Diabetes Care). All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (90 day supply). Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost	You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all rentals. Prior authorization is also required for purchases or repairs of each covered items totaling $1,000 or more. Blood glucose test strips: no Copay (limited to a 90 day supply from Ascensia Diabetes Care). Blood glucose monitor: no Copay (limited to one per year from Ascensia Diabetes Care). All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (90 day supply). Prosthetic devices: • 20% of the cost Related medical supplies: • 20% of the cost
20% of the cost Out-of-area dialysis services are covered only within the United States.	20% of the cost Out-of-area dialysis services are covered only within the United States.	20% of the cost Out-of-area dialysis services are covered only within the United States.
Doctor On Demand Visit: $0 Copay	Doctor On Demand Visit: $0 Copay	Doctor On Demand Visit: $0 Copay
Covered	Covered	Covered
$0 Copay	$0 Copay	$0 Copay
50% of the Medicare allowed amount	50% of the Medicare allowed amount	50% of the Medicare allowed amount
$50/Every 3 months	$50/Every 3 months	$50/Every 3 months
Covered	Covered	Covered
Covered	Covered	Covered

Important Information and Notes

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A plan for life.

Capital District Physicians' Health Plan, Inc.
CDPHP Universal Benefits,® Inc.
500 Patroon Creek Boulevard, Albany, NY 12206-1057

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