A plan for life.

CDPHP® Medicare Advantage PPO

SUMMARY OF BENEFITS

PPO

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21-16891

CDPHP® Medicare Advantage

CDPHP Vital Rx (PPO)
CDPHP Flex Rx (PPO)
CDPHP Flex (PPO)

2022 Summary of Benefits

January 1, 2022–December 31, 2022
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, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, 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 a PPO 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 Vital Rx (PPO), CDPHP Flex Rx (PPO), CDPHP Flex (PPO)—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 CDPHP?

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 Vital Rx (PPO), CDPHP Flex Rx (PPO), CDPHP Flex (PPO) have 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, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
Monthly Premium	$0.00 per month. You must keep paying your Medicare Part B premium.
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. • $11,300 for services you receive from in-network and out-of-network providers.

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
$42.00 per month. You must keep paying your Medicare Part B premium. This plan does not have a deductible. • $5,500 for services you receive from in-network providers. • $10,000 for services you receive from in-network and out-of-network providers.	$0.00 per month. You must keep paying your Medicare Part B premium. This plan does not have a deductible. • $5,500 for services you receive from in-network providers. • $10,000 for services you receive from in-network and out-of-network providers.

Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
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 [2]	**In-Network:** • $460 copay per day for days 1 through 4 • You pay nothing per day for days 5 through 90 **Out-of-Network:** 40% Coinsurance
Outpatient Hospital Coverage	**In-Network:** $395 Copay for observation services $395 Copay for outpatient surgery billed by a hospital **Out-of-Network:** 40% Coinsurance
Ambulatory Surgery	**In-Network:** $345 Copay for surgery at a freestanding ambulatory surgery center **Out-of-Network:** 40% Coinsurance
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay **Out-of-Network:** $50 Copay **In-Network:** Specialist visit: $45 Copay **Out-of-Network:** 40% Coinsurance
Preventive Care	**In-Network:** You pay nothing for Medicare approved preventive services **Out-of-Network:** 40% Coinsurance
Emergency Care	**In-Network:** $90 Copay (waived if admitted) **Out-of-Network:** $90 Copay
Urgently Needed Services	**In-Network:** $65 Copay **Out-of-Network:** $65 Copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these service may be different if received in an outpatient hospital setting)***	**In-Network:** Diagnostic radiology services (such as MRIs, CT scans): $220 Copay $0 Copay at preferred laboratory for outpatient and diagnostic laboratory services Diagnostic tests and procedures: 20% Coinsurance Lab services: $0–20% Coinsurance Outpatient X-rays: $45 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost **Out-of-Network:** Diagnostic radiology services (such as MRIs, CT scans): 40% Coinsurance Diagnostic tests and procedures: 40% coinsurance Outpatient X-rays: 40% Coinsurance Lab services: 40% Coinsurance Therapeutic radiology services (such as radiation therapy for cancer): 40% of the cost

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
COVERED MEDICAL BENEFITS	
Note: **• Services with a [1] may require prior authorization.** **• Services with a [2] may require a referral from your doctor.**	
In-Network: • $310 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 **Out-of-Network:** 30% Coinsurance	**In-Network:** • $310 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 **Out-of-Network:** 30% Coinsurance
In-Network: $325 Copay for observation services $325 Copay for outpatient surgery billed by a hospital **Out-of-Network:** 30% Coinsurance	**In-Network:** $325 Copay for observation services $325 Copay for outpatient surgery billed by a hospital **Out-of-Network:** 30% Coinsurance
In-Network: $250 Copay for surgery at a freestanding ambulatory surgery center **Out-of-Network:** 30% Coinsurance	**In-Network:** $250 Copay for surgery at a freestanding ambulatory surgery center **Out-of-Network:** 30% Coinsurance
In-Network: Primary care physician visit: $0 Copay **Out-of-Network:** $40 Copay **In-Network:** Specialist visit: $40 Copay **Out-of-Network:** 30% Coinsurance	**In-Network:** Primary care physician visit: $0 Copay **Out-of-Network:** $40 Copay **In-Network:** Specialist visit: $40 Copay **Out-of-Network:** 30% Coinsurance
In-Network: You pay nothing for Medicare approved preventive services **Out-of-Network:** 30% Coinsurance	**In-Network:** You pay nothing for Medicare approved preventive services **Out-of-Network:** 30% Coinsurance
In-Network: $90 Copay (waived if admitted) **Out-of-Network:** $90 Copay	**In-Network:** $90 Copay (waived if admitted) **Out-of-Network:** $90 Copay
In-Network: $60 Copay **Out-of-Network:** $60 Copay	**In-Network:** $60 Copay **Out-of-Network:** $60 Copay
In-Network: Diagnostic radiology services (such as MRIs, CT scans): $135 Copay $0 Copay at preferred laboratory for outpatient and diagnostic laboratory services Diagnostic tests and procedures: $40 Copay Lab services: $0–40 Copay Outpatient X-rays: $40 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost **Out-of-Network:** Diagnostic radiology services (such as MRIs, CT scans): 30% Coinsurance Diagnostic tests and procedures: 30% coinsurance Outpatient X-rays: $40 Copay Lab services: 30% Coinsurance Therapeutic radiology services (such as radiation therapy for cancer): 30% of the cost	**In-Network:** Diagnostic radiology services (such as MRIs, CT scans): $135 Copay $0 Copay at preferred laboratory for outpatient and diagnostic laboratory services Diagnostic tests and procedures: $40 Copay Lab services: $0–40 Copay Outpatient X-rays: $40 Copay Therapeutic radiology services (such as radiation therapy for cancer): 20% of the cost **Out-of-Network:** Diagnostic radiology services (such as MRIs, CT scans): 30% Coinsurance Diagnostic tests and procedures: 30% coinsurance Outpatient X-rays: $40 Copay Lab services: 30% Coinsurance Therapeutic radiology services (such as radiation therapy for cancer): 30% of the cost

Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
Hearing Services	**In-Network:** $45 Copay for a routine hearing exam **Out-of-Network:** 40% Coinsurance Covered Advanced Plus hearing aid: $599 Copay Covered Premium hearing aid: $899 Copay Hearing aids must be ordered through Hearing Care Solutions.
Dental Services	Preventive Dental services from a Participating Provider in Delta Dental's network for CDPHP Medicare Advantage plans. Limitations: • Oral exams are limited to one per calendar year. • Routine cleanings are limited to one per calendar year. • $20 for each covered bitewing X-ray • $30 for each covered panoramic X-ray • $30 for each covered full-mouth X-ray • X-rays are limited to one per calendar year. $20 Copay for a routine preventive dental exam at participating providers in Delta Dental's network for CDPHP Medicare Advantage plans. **In-Network:** $45 Copay for Medicare-covered non-routine dental services. **Delta Restorative (Non-Medicare Covered Comprehensive coverage) INN:** $60-$595 OON: N/A **Out-of-Network:** $250 reimbursement for all dental services outside the Delta Dental Network 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	**In-Network:** Routine eye exam: $20 Copay **Out-of-Network:** 40% Coinsurance Our plan pays up to $60 annually for eyewear.

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
In-Network: $45 Copay for a routine hearing exam **Out-of-Network:** $45 Copay Covered Advanced Plus hearing aid: $599 Copay Covered Premium hearing aid: $899 Copay Hearing aids must be ordered through Hearing Care Solutions.	**In-Network:** $45 Copay for a routine hearing exam **Out-of-Network:** $45 Copay Covered Advanced Plus hearing aid: $599 Copay Covered Premium hearing aid: $899 Copay Hearing aids must be ordered through Hearing Care Solutions.
Preventive Dental services from a Participating Provider in Delta Dental's network for CDPHP Medicare Advantage plans. Limitations: • Oral exams are limited to two per calendar year. • Routine cleanings are limited to two per calendar year. • $20 for each covered bitewing X-ray • $30 for each covered panoramic X-ray • $30 for each covered full-mouth X-ray • 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. **In-Network:** $40 Copay for Medicare-covered non-routine dental services. **Delta Restorative (Non-Medicare Covered Comprehensive coverage) INN:** $60-$595 OON: N/A **Out-of-Network:** $250 reimbursement for all dental services outside the Delta Dental Network 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 Participating Provider in Delta Dental's network for CDPHP Medicare Advantage plans. Limitations: • Oral exams are limited to two per calendar year. • Routine cleanings are limited to two per calendar year. • $20 for each covered bitewing X-ray • $30 for each covered panoramic X-ray • $30 for each covered full-mouth X-ray • 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. **In-Network:** $40 Copay for Medicare-covered non-routine dental services. **Delta Restorative (Non-Medicare Covered Comprehensive coverage) INN:** $60-$595 OON: N/A **Out-of-Network:** $250 reimbursement for all dental services outside the Delta Dental Network 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.
In-Network: Routine eye exam: $20 Copay **Out-of-Network:** 30% Coinsurance Our plan pays up to $125 every year for eyewear.	**In-Network:** Routine eye exam: $20 Copay **Out-of-Network:** 30% Coinsurance Our plan pays up to $125 every year for eyewear.

Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
Mental Health Services [2]	**In-Network:** Inpatient visit: • $330 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-Network:** 40% Coinsurance **In-Network:** Outpatient group therapy visit: $40 Copay **Out-of-Network:** 40% Coinsurance **In-Network:** Outpatient individual therapy visit: $40 Copay **Out-of-Network:** 40% Coinsurance
Skilled Nursing Facility [1, 2]	**In-Network:** • You pay nothing per day for days 1 through 20 • $184 Copay per day for days 21 through 100 Prior Authorization required **Out-of-Network:** 40% Coinsurance
Physical Therapy, Occupational Therapy and Speech Therapy	**In-Network:** Occupational therapy visit: $40 Copay **Out-of-Network:** 40% Coinsurance **In-Network:** Physical therapy and speech and language therapy visit: $40 Copay **Out-of-Network:** 40% Coinsurance
Ambulance [1]	**In-Network:** $265 Copay Prior Authorization required for Air Ambulance only **Out-of-Network:** $265 Copay
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.
Medicare Part B Drugs [1]	**In-Network:** 20% of the cost for chemotherapy drugs **Out-of-Network:** 40% Coinsurance **In-Network:** 20% of the cost for other Part B drugs **Out-of-Network:** 40% Coinsurance

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
In-Network: Inpatient visit: • $300 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-Network:** 30% Coinsurance	**In-Network:** Inpatient visit: • $300 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 **Out-of-Network:** 30% Coinsurance
In-Network: Outpatient group therapy visit: $40 Copay **Out-of-Network:** $60 Copay	**In-Network:** Outpatient group therapy visit: $40 Copay **Out-of-Network:** $60 Copay
In-Network: Outpatient individual therapy visit: $40 Copay **Out-of-Network:** $60 Copay	**In-Network:** Outpatient individual therapy visit: $40 Copay **Out-of-Network:** $60 Copay
In-Network: • You pay nothing per day for days 1 through 20 • $145 Copay per day for days 21 through 100 Prior Authorization required **Out-of-Network:** 30% Coinsurance	**In-Network:** • You pay nothing per day for days 1 through 20 • $145 Copay per day for days 21 through 100 Prior Authorization required **Out-of-Network:** 30% Coinsurance
In-Network: Occupational therapy visit: $40 Copay **Out-of-Network:** $60 Copay	**In-Network:** Occupational therapy visit: $40 Copay **Out-of-Network:** $60 Copay
In-Network: Physical therapy and speech and language therapy visit: $40 Copay **Out-of-Network:** $60 Copay	**In-Network:** Physical therapy and speech and language therapy visit: $40 Copay **Out-of-Network:** $60 Copay
In-Network: $255 Copay Prior Authorization required for Air Ambulance only **Out-of-Network:** $255 Copay	**In-Network:** $255 Copay Prior Authorization required for Air Ambulance only **Out-of-Network:** $255 Copay
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.
In-Network: 20% of the cost for chemotherapy drugs **Out-of-Network:** 30% Coinsurance	**In-Network:** 20% of the cost for chemotherapy drugs **Out-of-Network:** 30% Coinsurance
In-Network: 20% of the cost for other Part B drugs **Out-of-Network:** 30% Coinsurance	**In-Network:** 20% of the cost for other Part B drugs **Out-of-Network:** 30% Coinsurance

Summary of Benefits January 1, 2022–December 31, 2022

<table>
<tr><th>Benefit Category</th><th>CDPHP Vital Rx (PPO)</th></tr>
<tr><td colspan="2">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>$350 Medicare-defined Part D deductible.
This deductible applies to Tiers 3 through 5.</td></tr>
<tr><td>Phase 1: Initial Coverage
You pay the following until your total yearly drug costs reach $4,430. 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.</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>$3 Copay</td><td>$9 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$17 Copay</td><td>$51 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 Copay</td><td>$141 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 Copay</td><td>$300 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% of the cost</td><td>Not Offered</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>CDPHP Flex Rx (PPO)</th><th>CDPHP Flex (PPO)</th></tr>
<tr><td colspan="2">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></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>$14 Copay</td><td>$42 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$44 Copay</td><td>$132 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$95 Copay</td><td>$285 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr>
</table>
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</table>

Summary of Benefits January 1, 2022–December 31, 2022

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<tr><th>Benefit Category</th><th>CDPHP Vital Rx (PPO)</th></tr>
<tr><td>Preferred Mail Order Cost-Sharing</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>$17 Copay</td><td>$34 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 Copay</td><td>$94 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Brand)</td><td>$100 Copay</td><td>$250 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% of the cost</td><td>Not Offered</td></tr>
</table>
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.
</td></tr>
<tr><td>Non-Preferred Mail Order Cost-Sharing</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>$3 Copay</td><td>$9 Copay</td></tr>
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If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
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CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
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Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
Phase 2: 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 $4,430. 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 $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Phase 3: Catastrophic Coverage	After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% of the cost, or • $3.90 Copay for generic (including brand drugs treated as generic) and a $9.85 Copay for all other drugs.

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
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 $4,430. 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 $7,050, which is the end of the coverage gap. Not everyone will enter the coverage gap.	This plan does not cover Part D prescription drugs.
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $7,050, you pay the greater of: • 5% of the cost, or • $3.90 Copay for generic (including brand drugs treated as generic) and a $9.85 Copay for all other drugs.	

Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
ADDITIONAL COVERED MEDICAL BENEFITS	
aptihealth (behavorial health telemedicine app)	**In-Network:** Covered **Out-of Network:** N/A
Chiropractic Care	**In-Network:** $20 Copay **Out-of-Network:** 40% Coinsurance
Foot Care *(podiatry services)*	**In-Network:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $45 Copay **Out-of-Network:** 40% Coinsurance
Home Health Care	**In-Network:** You pay nothing. **Out-of-Network:** 40% Coinsurance
Insulin Covered through Part B	**In-Network:** $35 Copay **Out-of-Network:** 40% Coinsurance
Medical Equipment/Supplies [1]	**In-Network:** 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 **Out-of-Network:** 40% Coinsurance
MovN (cardiac rehab telehealth app)	**In-Network:** Covered **Out-of-Network:** N/A
Papa (social isolation benefit)	**In-Network:** Covered **Out-of-Network:** N/A
Renal Dialysis	**In-Network:** 20% of the cost **Out-of-Network:** 40% Coinsurance Out-of-area dialysis services are covered only within the United States.

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
ADDITIONAL COVERED MEDICAL BENEFITS	
In-Network: Covered **Out-of Network:** N/A	**In-Network:** Covered **Out-of Network:** N/A
In-Network: $20 Copay **Out-of-Network:** 30% Coinsurance	**In-Network:** $20 Copay **Out-of-Network:** 30% Coinsurance
In-Network: Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $40 Copay **Out-of-Network:** $60 Copay	**In-Network:** Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $40 Copay **Out-of-Network:** $60 Copay
In-Network: You pay nothing. **Out-of-Network:** 30% Coinsurance	**In-Network:** You pay nothing. **Out-of-Network:** 30% Coinsurance
In-Network: $35 Copay **Out-of-Network:** 30% Coinsurance	**In-Network:** $35 Copay **Out-of-Network:** 30% Coinsurance
In-Network: 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 **Out-of-Network:** 30% Coinsurance	**In-Network:** 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 **Out-of-Network:** 30% Coinsurance
In-Network: Covered **Out-of-Network:** N/A	**In-Network:** Covered **Out-of-Network:** N/A
In-Network: Covered **Out-of-Network:** N/A	**In-Network:** Covered **Out-of-Network:** N/A
In-Network: 20% of the cost **Out-of-Network:** 30% Coinsurance Out-of-area dialysis services are covered only within the United States.	**In-Network:** 20% Coinsurance **Out-of-Network:** 30% Coinsurance Out-of-area dialysis services are covered only within the United States.

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Summary of Benefits January 1, 2022–December 31, 2022

Benefit Category	CDPHP Vital Rx (PPO)
ADDITIONAL COVERED MEDICAL BENEFITS	
Telemedicine Visit	**In-Network:** $0-45 Copay **Out-of-Network:** Not covered
Wellness Programs CDPHP Senior Fit®—Access SilverSneakers® gyms, Capital District YMCA and Glens Falls YMCA locations, and more. Life Points® from CaféWell®—Earn up to $125 in Life Points from CaféWell by registering online and completing personalized health and wellness programs.	No cost
Acupuncture 10 visits for any condition 12 visits for diagnosis of chronic back pain	50% of the Medicare allowed amount INN/ 50% of the Medicare allowed amount OON
Over-the-Counter (OTC) Items	**In-Network:** $25 quarter **Out-of-Network:** Not covered
Mom's Meals (home-delivered meal benefit)	**In-Network:** Covered **Out-of-Network:** Not covered
Foodsmart (telenutrition services)	**In-Network:** Covered **Out-of-Network:** Not covered
In-home Palliative Medical Care	**In-Network:** $0 Copay **Out-of-Network:** Not covered

CDPHP Flex Rx (PPO)	CDPHP Flex (PPO)
ADDITIONAL COVERED MEDICAL BENEFITS	
In-Network: $0-40 Copay **Out-of-Network:** Not covered	**In-Network:** $0-40 Copay **Out-of-Network:** Not covered
No cost	No cost
50% of the Medicare allowed amount INN/ 50% of the Medicare allowed amount OON	50% of the Medicare allowed amount INN/ 50% of the Medicare allowed amount OON
In-Network: $25 quarter **Out-of-Network:** Not covered	**In-Network:** $25 quarter **Out-of-Network:** Not covered
In-Network: Covered **Out-of-Network:** Not covered	**In-Network:** Covered **Out-of-Network:** Not covered
In-Network: Covered **Out-of-Network:** Not covered	**In-Network:** Covered **Out-of-Network:** Not covered
In-Network: $0 Copay **Out-of-Network:** Not covered	**In-Network:** $0 Copay **Out-of-Network:** Not covered

Important Information and Notes

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A plan for life.

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