A plan for life.

2024

PLAN COMPARISION

CDPHP FEHB Standard Plan to CDPHP Medicare Advantage Extra

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NOTES:

CDPHP FEHB Standard Plan Members:

Did you know OPM now allows FEHB health insurance carriers to offer Medicare Advantage plans to their federal members?

CDPHP is excited to offer qualified members of our FEHB Standard Plan the new **CDPHP® Medicare Advantage Extra**. As a dually-enrolled member, you can experience reduced health care payments, lower prescription drug costs, and many healthy extras to help you live your healthiest life.

And you can get reimbursed up to $1,980 per year by enrolling! CDPHP Medicare Advantage Extra can get you up to $165 back each month to cover Part B premiums. (*Plan requirements apply*.)

YOU CAN ALSO ENJOY:

- Lower copays and payments
- Worldwide emergency coverage
- Access to 15,000+ gyms at no additional cost through SilverSneakers, including CDPHP Fitness Connect℠ at the Ciccotti Center
- $0 preventive care like flu shots, cancer screenings, and more
- Hearing aids for as little as $199 each
- 14 home-delivered meals following an inpatient stay at a hospital, skilled nursing, or rehab facility

INTERESTED? TO QUALIFY, YOU'LL NEED TO:

- Continue, or start, your coverage under the CDPHP FEHB Standard Option Plan
- Have Medicare Parts A and B
- Reside in our 29-county service area for at least six months of the year
- Be retired and/or a federal annuitant
- Contact CDPHP Medicare Advantage Extra at the number below

Call 1-877-480-3328 (TTY: 711) to speak with a representative and request an enrollment packet or enroll over the phone.

Our hours are 8 a.m. - 8 p.m. seven days a week from October 1 - March 31. From April 1 - September 30, Monday – Friday, our hours are 8 a.m. - 8 p.m. A voice messaging service is used weekends, after-hours, and federal holidays. Calls will be returned within one business day.

Benefits	2024 FEHB Standard Plan	2024 CDPHP Medicare Advantage Extra (PPO Rx)	
Network	In network only	In network	Out of network
Self Only Deductible	$350 *Only where noted*	N/A	N/A
Self Plus One/Self and Family Deductible	$700 *Only where noted*	N/A	N/A
Primary Care Physician	$40 copayment	$15 copayment	$50 copayment
Routine Annual Physical Exam	Covered in full	Covered in full	30% coinsurance
Specialty Visits	$60 copayment	$20 copayment	30% coinsurance
Allergy Injections	Covered in full	Covered in full	30% coinsurance
Part B Medications Physician administered injectables (including chemotherapy) or Retail pharmacy/Oral chemotherapy	No copayment	No copayment	30% coinsurance
Maternity Outpatient Visits	$40 initial visit Covered in full thereafter	$20 copayment	$50 initial visit Covered in full thereafter
Well-Baby & Well-Child Visits, including Immunizations and Inoculations	Covered in full	Covered in full (only for Medicare-eligible children)	30% coinsurance (only for Medicare-eligible children)
Outpatient Mental Health	$40 copayment	$20 copayment	30% coinsurance
Outpatient Alcohol/Substance Abuse	$40 copayment	$20 copayment	30% coinsurance
Outpatient Surgery	$100 copayment *Subject to calendar year deductible*	$75 copayment	30% coinsurance
Emergency Care	$150 copayment *Subject to calendar year deductible*	$75 copayment (waived if admitted)	$75 copayment (waived if admitted)
Urgent Care	$60 copayment	$50 copayment	$50 copayment
Ambulance Services	$100 copayment *Subject to calendar year deductible*	$100 copayment	$100 copayment
DME	50% of the Plan allowance *Must be preauthorized if cost is over $1,000 or item is rented.* *Subject to calendar year deductible*	20% coinsurance	30% coinsurance
Prosthetic Devices	50% of the Plan allowance *Must be preauthorized if cost is over $1,000 or item is rented.* *Subject to calendar year deductible*	20% coinsurance	30% coinsurance
X-rays/Ultrasounds	$60 copayment *Waived if preferred site*	$20 copayment	30% coinsurance
Advanced Imaging (CT Scan, MRI, PET Scan)	$60 copayment *Waived if preferred site*	$40 copayment	30% coinsurance
Lab Services	$60 copayment *Waived if preferred site*	$20 copayment *Waived if preferred site*	30% coinsurance
Radiation Therapy	$40 copayment	$20 copayment	30% coinsurance
Chiropractic Care	$60 copayment	$20 copayment	30% coinsurance

Benefits	2024 FEHB Standard Plan	2024 CDPHP Medicare Advantage Extra (PPO Rx)	
Network	In network only	In network	Out of network
Medically Necessary Foot Care	$40/ $60 copayment *Depending on place of service*	$20 copayment	30% coinsurance
Routine Foot Care	Not covered	Not covered	Not covered
Physical Therapy	$60 copayment *60 visits per calendar year* *20% of the Plan allowance for inpatient services* *(calendar year deductible applies)*	$20 copayment, no visit limit per benefit period	30% coinsurance no visit limit per benefit period
Occupational Therapy	$60 copayment *60 visits per calendar year* *20% of the Plan allowance for inpatient services* *(calendar year deductible applies)*	$20 copayment, no visit limit per benefit period	30% coinsurance no visit limit per benefit period
Speech Therapy	$60 copayment *60 visits per calendar year* *20% of the Plan allowance for inpatient services* *(calendar year deductible applies)*	$20 copayment, no visit limit per benefit period	30% coinsurance no visit limit per benefit period
Inpatient Hospitalization	$500 per admission plus 20% of the Plan allowance. *(calendar year deductible applies)* *Individual, limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year.)*	$250 copayment per admission *Max 2 payments per plan year*	30% coinsurance
Inpatient Nursery Care	Covered in full	Covered in full *(only for Medicare-eligible children)*	30% coinsurance
Inpatient Mental Health	$500 per admission plus 20% of the Plan allowance. *(calendar year deductible applies)* *For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.*	$250 copayment per admission *Max 2 payments per plan year*	30% coinsurance
Inpatient Alcohol/Substance Abuse	$500 per admission plus 20% of the Plan allowance. *(calendar year deductible applies)* *For individual coverage, inpatient copays are limited to two per calendar year. For family coverage, inpatient copays are limited to three per calendar year. The copayment does not apply to hospital inpatient charges for newborn nursery care.*	$250 copayment per admission *Max 2 payments per plan year*	30% coinsurance
Skilled Nursing Facility	$500 per admission plus 20% of the Plan allowance. *(calendar year deductible applies)*	$250 copayment per admission *Max 2 payments per plan year*	30% coinsurance
Home Health Services	Covered in full	Covered in full	30% coinsurance
Mammograms	Covered in full	Covered in full	30% coinsurance
Colorectal Screening Exams	Covered in full	Covered in full	30% coinsurance
Flu, Pneumonia, & Hepatitis B	Covered in full	Covered in full	30% coinsurance

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Prescription Drugs	**Tier 1 drugs - $10 copayment** *(2.5 copayments will apply for 90-day supplies of maintenance medications obtained by mail order)* **Tier 2 drugs - 50% of the Plan allowance with a $400 per prescription maximum** *up to a 30-day supply* **Tier 3 drugs - 50% of the Plan allowance with a $600 per prescription maximum** *up to a 30-day supply* *Member pharmacy cost share will apply toward the annual out-of-pocket maximum.*	6 Tier $0/$10/$30/$50/$55/$0 2 copayments for 90-day supply via mail order Tiers 1-4	N/A
Diabetic Care	Insulin and oral medications: $40 copayment per item Diabetic supplies (Insulin, oral agents to control blood sugar, needles, test strips, lancets, and visual reading and urine test strips.): $40 copayment Diabetic DME (Durable medical equipment for insulin dependent persons/insulin pumps): $40 copayment	**PART B:** Insulin used in an insulin pump is considered Part B and will have no copayment when filled at a network pharmacy. Out of network pharmacy claims are not covered. Diabetic blood glucose monitors (limited to one per year) and blood glucose test strips (limited to a 30-day supply). No copayment for Ascensia or OneTouch Diabetes Care items; if you use a monitor or test strips made by a different manufacturer, contact member services for more information or to request an exception. Diabetic supplies (lancets, glucose control solutions, insulin pump supplies, reservoirs, etc.): 20% coinsurance or $10 copayment, whichever is less. Out of network pharmacy claims are not covered. Diabetic DME, (insulin pumps): $40 copayment **PART D:** Insulin, diabetic insulin needles, syringes: covered under Part D prescription portion of the plan. Based on the benefit the member cost share for in-network will consist of the appropriate tier prescription copay of $0/$10/$30/$50/$55/$0.	**PART B:** Prior authorization may be required and is the responsibility of your provider. 30% coinsurance per Medicare-covered Part B drug. **PART D:** N/A If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. Coverage is limited to up to a 30-day supply in certain situations and subject to prior authorization. See Chapter 5 section 2.5 in your *Evidence of Coverage* for further information.
Diabetic Prevention Program	VP Transform	VP Transform- Medicare Diabetes prevention Program covered in full	N/A
Telemedicine – preferred *Doctor on Demand. Aptihealth, Movin*	$0 copayment	$0 copayment	N/A
Telehealth *all other outside preferred*	$40/$60	$20 copayment	30% coinsurance
Vision Services	Eyeglasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity. 50% of the Plan allowance *(calendar year deductible applies)* Routine eye exam and eye refractions once every 24 months and Eye exercises and orthoptics when approved $ 60 per office visit	Eyeglasses or contact lenses necessitated by certain medical conditions such as aphakia, keratoconus, or endocrine exophthalmos or following intraocular surgery. Replacement reviewed based on medical necessity. 20% of the Plan allowance $20 routine eye exam	30% coinsurance

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Hearing Services	$60 per office visit Implanted hearing device 50% of the Plan allowance. *Must be preauthorized if cost is over $1,000.* *(Calendar year deductible applies)* Per external hearing aid device through Hearing Care Solutions - $599 Premium hearing aid/$899 Premier hearing aid	$20 per office visit Implanted hearing device 20% of the Plan allowance. *Must be preauthorized if cost is over $1,000.* Per external hearing aid device through Hearing Care Solutions - $199 Premium hearing aid $499 Premier hearing aid	30% coinsurance per office visit Implanted hearing device 30% coinsurance *Must be preauthorized if cost is over $1,000.* Per external hearing aid device only available in network through hearing care solutions
Preventive dental	Not covered	Not covered	Not covered
Health/Wellness	$75 weight management reimbursement	**Weight Management Program** *Receive up to $100 reimbursement for participation in a weight loss program. with an eligible vendor* **CDPHP Senior Fit®:** *Enjoy access to SilverSneakers® at participating gyms. You can also work out and take fitness and wellness classes at many other area gyms, like the CDPHP® Fitness Connect at the Ciccotti Center* **In-Home Support** *Thirty hours of in-home support services provided by Papa Pals, including help around the house, transportation, companionship, and technology lesson.* **Meals after hospital discharge** *14 home-delivered following an inpatient stay at a hospital, skilled nursing facility, or rehab facility at no charge*	N/A
Travel Out-of-Area Routine Care Benefit	Not covered	See out of network benefits	N/A
Annual Out of Pocket Maximum	$8,550 *Self Only* $17,100 *Self Plus One/Self and Family*	$3,850 *for covered medical services received in network*	$5,750 *Combined in and out of network*
Medicare part A + B primary waivers	PCP/ Specialist *copays are waived*	$165 per month reimbursement *for Medicare Part B premium payments* *Must be simultaneously enrolled in the CDPHP Standard Plan and the CDPHP Medicare Advantage Extra Plan to be eligible for this reimbursement.*	

This summary is designed to highlight the benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. For more detailed information, a membership certificate is available for your review upon request.

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