2024 Summary of Benefits

Medicare Advantage Plan

CDPHP® Choice (HMO)

CDPHP® Choice Rx (HMO)

January 1, 2024 – December 31, 2024

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1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the **"Evidence of Coverage"**. You can also see the Evidence of Coverage on our website, www.https://www.cdphp.com/medicare.

You have choices about how to get your Medicare benefits

- One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.
- Another choice is to get your Medicare benefits by joining a Medicare health plan (such as **CDPHP® Choice (HMO)** and **CDPHP® Choice Rx (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CDPHP® Choice (HMO)** and **CDPHP® Choice Rx (HMO)** covers and what you pay.

- If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **CDPHP® Choice (HMO)** and **CDPHP® Choice Rx (HMO)**.
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services.
- Covered Medical and Hospital Benefits.

This document is available in other formats such as Braille and large print.

This document may be available in a non-English language. For additional information, call us at 1-888-248-6522 (TTY: 711).

Things to Know About CDPHP® Choice (HMO) and CDPHP® Choice Rx (HMO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-248-6522, TTY: 711.

- If you are not a member of this plan, call us at 1-888-519-4455, TTY: 711.
- Our website: www.https://www.cdphp.com/medicare.

Who can join?

To join **CDPHP® Choice (HMO) and CDPHP® Choice Rx (HMO)** , you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area for **CDPHP® Choice (HMO)** includes the following counties in New York: 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.
The service area for **CDPHP® Choice Rx (HMO)** includes the following counties in New York: 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.

What do we cover?

Like all Medicare health plans, we cover everything that Original Medicare covers – and *more*. Some of the extra benefits are outlined in this booklet.

In addition, we cover Part B drugs including chemotherapy and some drugs administered by your provider.

- You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, www.https://www.cdphp.com/medicare.
- Or, call us and we will send you a copy of the formulary.

If you have any questions about this plan's benefits or costs, please contact CDPHP Medicare Advantage

2 SECTION II - SUMMARY OF BENEFITS

	CDPHP® Choice (HMO)	CDPHP® Choice Rx (HMO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES		
Monthly Plan Premium	$39.90 per month. In addition, you must keep paying your Medicare Part B premiums.	$124 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: Not Applicable.	Medical Deductible: Not Applicable.

		Prescription Drug Deductible: Not Applicable.
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $6,100 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums.	Your yearly limit(s) in this plan: • $6,100 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Inpatient Hospital	**In-Network:** Days 1-6: $260 Copay per day for each admission. Days 7-90: $0 Copay per day. May require prior authorization.	**In-Network:** Days 1-6: $260 Copay per day for each admission. Days 7-90: $0 Copay per day. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $200 Copay. Outpatient Surgery: $150 Copay. May require prior authorization.	**In-Network:** Outpatient hospital: $200 Copay. Outpatient Surgery: $150 Copay. May require prior authorization.
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $150 Copay. May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $150 Copay. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $25 Copay. May require prior authorization.	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $25 Copay. May require prior authorization.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered.
Emergency Care	**In-Network:** $90 Copay per visit. Worldwide Emergency Coverage: $90 Copay.	**In-Network:** $90 Copay per visit. Worldwide Emergency Coverage: $90 Copay.
Urgently Needed Services	**In-Network:** $45 Copay per visit. Worldwide Urgent Coverage: $45 Copay.	**In-Network:** $45 Copay per visit. Worldwide Urgent Coverage: $45 Copay.
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0* - $25 Copay. Lab services: $0* - $5 Copay. *Copay waived at preferred providers Diagnostic Radiology Services (such as MRI, CAT Scan): $100 Copay X-rays: $25 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.	**In-Network:** Diagnostic tests and procedures: $0* - $25 Copay. Lab services: $0* - $5 Copay. *Copay waived at preferred providers Diagnostic Radiology Services (such as MRI, CAT Scan): $100 Copay X-rays: $25 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. May require prior authorization.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $25 Copay. Routine hearing exam (up to 1 visit(s) every year): $25 Copay.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $25 Copay. Routine hearing exam (up to 1 visit(s) every year): $25 Copay.

COVERED MEDICAL AND HOSPITAL BENEFITS		
	Hearing Aid (up to 2 hearing aids every year): $199 - $499 Copay.	Hearing Aid (up to 2 hearing aids every year): $199 - $499 Copay.
Dental Services	**In-Network:** Medicare Covered: $25 Copay. Preventive and restorative dental services: You have a $1,500 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider	**In-Network:** Medicare Covered: $25 Copay. Preventive and restorative dental services: You have a $1,500 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider
Telemedicine	**In-Network:** $0 - $25 Copay.	**In-Network:** $0 - $25 Copay.
Over-the-Counter (OTC Items)	$75/Quarter on a prepaid Benefits Mastercard	$75/Quarter on a prepaid Benefits Mastercard
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $25 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: 20% Coinsurance. Our plan reimburses up to $250 every year for eyewear.	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $25 Copay. Routine eye exam (up to 1 visit(s) every year): $0 Copay. Eyeglasses or contact lenses after cataract surgery: 20% Coinsurance. Our plan reimburses up to $250 every year for eyewear.

COVERED MEDICAL AND HOSPITAL BENEFITS		
Mental Health Care	**In-Network:** Inpatient Mental Health Care: Days 1-6: $260 Copay per day for each admission. Days 7-90: $0 Copay per day. Outpatient group therapy visit: $25 Copay. Outpatient Individual therapy visit: $25 Copay.	**In-Network:** Inpatient Mental Health Care: Days 1-6: $260 Copay per day for each admission. Days 7-90: $0 Copay per day. Outpatient group therapy visit: $25 Copay. Outpatient Individual therapy visit: $25 Copay.
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $120 Copay per day. May require prior authorization.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $120 Copay per day. May require prior authorization.
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.	**In-Network:** Occupational therapy visit: $25 Copay. Physical therapy and speech and language therapy visit: $25 Copay.
Ambulance	**In-Network:** Ground Ambulance: $165 Copay. Air Ambulance: $165 Copay.	**In-Network:** Ground Ambulance: $165 Copay. Air Ambulance: $165 Copay.
Transportation	**In-Network:** $0 Copay No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.	**In-Network:** $0 Copay No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.

<table>
<tr><th colspan="3">COVERED MEDICAL AND HOSPITAL BENEFITS</th></tr>
<tr><td>Medicare Part B Drugs</td><td><u>In-Network:</u>
For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
Other Part B drugs: $35 Copay - 20% Coinsurance.
May require prior authorization.</td><td><u>In-Network:</u>
For Part B drugs such as chemotherapy drugs: 20% Coinsurance.
Other Part B drugs: $35 Copay - 20% Coinsurance.
May require prior authorization.</td></tr>
<tr><th colspan="3">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr><td>Deductible</td><td>This plan does not cover Part D Prescription Drugs.</td><td>Prescription Drug Deductible: Not Applicable.</td></tr>
<tr><td>Initial Coverage</td><td>This plan does not cover Part D Prescription Drugs.</td><td>You pay the following until your total yearly drug costs reach $5,030. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

<table><tr><th colspan="2">Standard Retail Cost-Sharing</th></tr><tr><th>Tier</th><th>One-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$3 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$16 copay</td></tr><tr><td>Tier 3 (Preferred Brand)</td><td>$45 copay</td></tr><tr><td>Tier 4 (Non-Preferred Drug)</td><td>$90 copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% coinsurance</td></tr></table>
<table><tr><th>Tier</th><th>Three-month supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$9 copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$48 copay</td></tr></table></td></tr>
</table>

This plan does not cover Part D Prescription Drugs.

Tier 3 (Preferred Brand)	$135 copay
Tier 4 (Non-Preferred Drug)	$270 copay
Tier 5 (Specialty Tier)	Not Applicable

Preferred Retail Cost-Sharing	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0
Tier 2 (Generic)	$0
Tier 3 (Preferred Brand)	$40
Tier 4 (Non-Preferred Drug)	$90
Tier 5 (Specialty Tier)	33% Coinsurance

Standard Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$3 copay
Tier 2 (Generic)	$16 copay
Tier 3 (Preferred Brand)	$45 copay
Tier 4 (Non-Preferred Drug)	$90 copay
Tier 5 (Specialty Tier)	33% coinsurance

Tier	**Three-month supply**
Tier 1 (Preferred Generic)	$9 copay

	This plan does not cover Part D Prescription Drugs.	

Tier 2 (Generic)	$48 copay
Tier 3 (Preferred Brand)	$135 copay
Tier 4 (Non-Preferred Drug)	$270 copay
Tier 5 (Specialty Tier)	Not Applicable

Preferred Mail Order	
Tier	**One-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$0 Copay
Tier 3 (Preferred Brand)	$40 copay
Tier 4 (Non-Preferred Drug)	$90 copay
Tier 5 (Specialty Tier)	33% coinsurance

Tier	**Three-month supply**
Tier 1 (Preferred Generic)	$0 Copay
Tier 2 (Generic)	$0 Copay
Tier 3 (Preferred Brand)	$80 copay
Tier 4 (Non-Preferred Drug)	$225 copay
Tier 5 (Specialty Tier)	Not Applicable

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.

		Please call us or see the plan's **"Evidence of Coverage"** on our website (www.https://www.cdphp.com/medicare) for complete information about your costs for covered drugs.
Coverage Gap	This plan does not cover Part D Prescription Drugs.	The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030. 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 $8,000, which is the end of the coverage gap. Not everyone will enter the coverage gap.
Catastrophic Coverage	This plan does not cover Part D Prescription Drugs.	After your yearly out-of-pocket drug costs reach $8,000, your prescription drugs are covered in full.

DISCLAIMERS

This document is available in other alternate formats.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-888-248-6522 (TTY: 711).

ATENCIÓN: Si habla español, hay servicios de traducción, libre de cargos, disponibles para usted. Llame al 1-888-519-4455 (TTY: 711).

CDPHP® Choice (HMO) and **CDPHP® Choice Rx (HMO)** is a HMO plan with a Medicare contract. Enrollment in **CDPHP® Choice (HMO)** and **CDPHP® Choice Rx (HMO)** depends on contract renewal.

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year.

You must continue to pay your Medicare Part B premium.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

Out-of-network/non-contracted providers are under no obligation to treat CDPHP Medicare Advantage members, except in emergency situations. For a decision about whether we will cover an out-of-network service, we encourage you or your provider to ask us for a pre-service organization determination before you receive the service. Please call our Member Services number or see your “Evidence of Coverage” for more information, including the cost-sharing that applies to out-of-network services.

Health coverage is offered by Capital District Physicians' Health Plan, Inc.

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at 1-888-248-6522 (TTY 711).

Understanding the Benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit www.https://www.cdphp.com/medicare or call 1-888-248-6522 (TTY 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the formulary to make sure your drugs are covered.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2025.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).

- ☐ Effect on Current Coverage. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

THANK YOU

Connect with us

Contact Information: 1-888-248-6522, TTY: 711

Organization Name: Capital District Physicians' Health Plan, Inc.

Organization website: https://www.cdphp.com/medicare