A plan for life.

CDPHP® Medicare Advantage HMO

SUMMARY OF BENEFITS

Y0019_23_20389_M

22-20389

CDPHP® Medicare Advantage

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

2023 Summary of Benefits

January 1, 2023–December 31, 2023

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 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 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 $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, 2023–December 31, 2023

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)	• $7,000 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)
$58.30 per month. You must keep paying your Medicare Part B premium. This plan does not have a deductible. • $6,400 for services you receive from in-network providers.	$39.90 per month. You must keep paying your Medicare Part B premium. This plan does not have a deductible. • $6,100 for services you receive from in-network providers.	$128.50 per month. You must keep paying your Medicare Part B premium. This plan does not have a deductible. • $6,100 for services you receive from in-network providers.

Summary of Benefits January 1, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
COVERED MEDICAL BENEFITS		
Note: **• Services with a [1] may require prior authorization.** **• Your primary care physician (PCP) may need to refer you for certain services.**		
Inpatient Hospital Care	• $330 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90	• $315 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90
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: $35 Copay	Primary care physician visit: $0 Copay Specialist visit: $35 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	$60 Copay	$60 Copay
Diagnostic Tests, Lab and Radiology Services, and X-Rays [1] ***(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: $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): $140 Copay Diagnostic tests and procedures: $35 Copay Lab services: $0–$5 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
Hearing 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: $35 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.** **• Your primary care physician (PCP) may need to refer you for certain services.**		
• $295 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90	• $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90	• $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90
$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: $30 Copay	Primary care physician visit: $0 Copay Specialist visit: $25 Copay	Primary care physician visit: $0 Copay Specialist visit: $25 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	$50 Copay	$50 Copay
Diagnostic radiology services (such as MRIs, CT scans): $130 Copay Diagnostic tests and procedures: $30 Copay Lab services: $0–$5 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: $25 Copay Lab services: $0–$5 Copay Outpatient X-rays: $25 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: $25 Copay Lab services: $0–$5 Copay Outpatient X-rays: $25 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
Routine hearing exam: $30 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: $25 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: $25 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, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Dental Services	$675 maximum reimbursement for all dental services per plan year. Reimbursement may not be used for teeth whitening. $35 Copay for Medicare-covered non-routine dental services.	$725 maximum reimbursement for all dental services per plan year. Reimbursement may not be used for teeth whitening. $35 Copay for Medicare-covered non-routine dental services.
Vision Services	Routine eye exam: $20 Copay Our plan pays up to $175 every year for eyewear	Routine eye exam: $20 Copay Our plan pays up to $215 every year for eyewear

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
$750 maximum reimbursement for all dental services per plan year. Reimbursement may not be used for teeth whitening. $30 Copay for Medicare-covered non-routine dental services.	$750 maximum reimbursement for all dental services per plan year. Reimbursement may not be used for teeth whitening. $25 Copay for Medicare-covered non-routine dental services.	$750 maximum reimbursement for all dental services per plan year. Reimbursement may not be used for teeth whitening. $25 Copay for Medicare-covered non-routine dental services.
Routine eye exam: $20 Copay Our plan pays up to $200 every year for eyewear.	Routine eye exam: $0 Copay Our plan pays up to $250 every year for eyewear.	Routine eye exam: $0 Copay Our plan pays up to $250 every year for eyewear.

Summary of Benefits January 1, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Mental Health Care	Inpatient visit: • $300 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $35 Copay Outpatient individual therapy visit: $35 Copay	Inpatient visit: • $315 Copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 Outpatient group therapy visit: $35 Copay Outpatient individual therapy visit: $35 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: $35 Copay Physical therapy and speech and language therapy visit: $35 Copay	Occupational therapy visit: $35 Copay Physical therapy and speech and language therapy visit: $35 Copay
Ambulance [1]	$265 Copay Prior Authorization required for Air Ambulance only	$260 Copay Prior Authorization required for Air Ambulance only
Transportation	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 through 90 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 through 90 Outpatient group therapy visit: $25 Copay Outpatient individual therapy visit: $25 Copay	Inpatient visit: • $260 Copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 Outpatient group therapy visit: $25 Copay Outpatient individual therapy visit: $25 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: $30 Copay Physical therapy and speech and language therapy visit: $30 Copay	Occupational therapy visit: $25 Copay Physical therapy and speech and language therapy visit: $25 Copay	Occupational therapy visit: $25 Copay Physical therapy and speech and language therapy visit: $25 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, 2023–December 31, 2023

<table>
<tr><th>Benefit Category</th><th>$0 Medicare Rx (HMO)</th><th>Basic Rx (HMO)</th></tr>
<tr><td colspan="3">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>Deductible</td><td>$250 Medicare-defined Part D deductible. This deductible applies to Tiers 3 through 5.</td><td>This plan does not have an Rx deductible.</td></tr>
<tr><td>Phase 1: Initial Coverage
You pay the following until your total yearly drug costs reach $4,660. 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.

During this stage, your out-of-pocket costs for select insulins will be $35.</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 Drug)</td><td>$100 Copay</td><td>$300 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>27% of the cost</td><td>Not Offered</td></tr>
</table>
</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>$15 Copay</td><td>$45 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$45 Copay</td><td>$135 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$97 Copay</td><td>$291 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr>
</table>
</td></tr>
</table>

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
PRESCRIPTION DRUG BENEFITS		
This plan does not have an Rx deductible.	This plan does not cover Part D prescription drugs.	This plan does not have an Rx deductible.

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 Offered

This plan does not cover Part D prescription drug.

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 Offered

Summary of Benefits January 1, 2023–December 31, 2023

<table>
<tr><th>Benefit Category</th><th>$0 Medicare Rx (HMO)</th><th>Basic Rx (HMO)</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>$0 Copay</td><td>$0 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 Drug)</td><td>$100 Copay</td><td>$250 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>27% 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><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>$0 Copay</td><td>$0 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$45 Copay</td><td>$90 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$97 Copay</td><td>$242.50 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% 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>
<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 Drug)</td><td>$100 Copay</td><td>$300 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>27% of the cost</td><td>Not Covered</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><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>$15 Copay</td><td>$45 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$45 Copay</td><td>$135 Copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$97 Copay</td><td>$291 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Covered</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>
</table>

CDPHP Value Rx (HMO)			CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)	
Tier	**One Month Supply**	**Three Month Supply**		Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$0 Copay	$0 Copay		Tier 2 (Generic)	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	$42 Copay	$84 Copay		Tier 3 (Preferred Brand)	$40 Copay	$80 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay	$232.50 Copay		Tier 4 (Non-Preferred Drug)	$90 Copay	$225 Copay
Tier 5 (Specialty Tier)	33% 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.				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.				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	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$2 Copay	$6 Copay		Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$13 Copay	$39 Copay		Tier 2 (Generic)	$11 Copay	$33 Copay
Tier 3 (Preferred Brand)	$42 Copay	$126 Copay		Tier 3 (Preferred Brand)	$40 Copay	$120 Copay
Tier 4 (Non-Preferred Drug)	$93 Copay	$279 Copay		Tier 4 (Non-Preferred Drug)	$90 Copay	$270 Copay
Tier 5 (Specialty Tier)	33% 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.				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.				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, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
Coverage Gap During this stage, your out-of-pocket costs for select insulins will be $35.	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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: • 5% of the cost, or • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 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 $7,400, you pay the greater of: • 5% of the cost, or • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 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 $4,660. 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 $7,400, 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 $4,660. 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 $7,400, 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 $7,400, you pay the greater of: • 5% of the cost, or • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 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 $7,400, you pay the greater of: • 5% of the cost, or • $4.15 Copay for generic (including brand drugs treated as generic) and a $10.35 Copay for all other drugs.

Summary of Benefits January 1, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
ADDITIONAL COVERED MEDICAL BENEFITS		
aptihealth (behavorial health telemedicine app)	$0 Copay	$0 Copay
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: $35 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $35 Copay
Home Health Care	You pay nothing.	You pay nothing.
Insulin covered through Part B	$35 Copay per 30 day supply	$35 Copay per 30 day supply
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
MovN (cardiac rehab telehealth app)	Covered	Covered
Papa (in-home support services) 30 hours per year of companionship and assistance with Instrumental Activities of Daily Living (IADLs)	Covered	Covered
Renal 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	$0–$35 Copay	$0–$35 Copay

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
ADDITIONAL COVERED MEDICAL BENEFITS		
$0 Copay	$0 Copay	$0 Copay
$20 Copay	$20 Copay	$20 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: $25 Copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $25 Copay
You pay nothing.	You pay nothing.	You pay nothing.
$35 Copay per 30 day supply	$35 Copay per 30 day supply	$35 Copay per 30 day supply
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: Lesser of 20% or $250 max per item Related medical supplies: Lesser of 20% or $250 max per item	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: Lesser of 20% or $250 max per item Related medical supplies: Lesser of 20% or $250 max per item	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: Lesser of 20% or $250 max per item Related medical supplies: Lesser of 20% or $250 max per item
Covered	Covered	Covered
Covered	Covered	Covered
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.
$0–$30 Copay	$0–$25 Copay	$0–$25 Copay

(continued on next page)

Summary of Benefits January 1, 2023–December 31, 2023

Benefit Category	$0 Medicare Rx (HMO)	Basic Rx (HMO)
ADDITIONAL COVERED MEDICAL BENEFITS		
Wellness Programs Senior Fit®—Enjoy no-cost access to thousands of SilverSneakers® fitness locations, hundreds of online fitness classes, and more. CDPHP Health Hub—Complete wellness activities and earn up to $175 in Life Points Rewards redeemable for gift cards and other merchandise.	Covered	Covered
Foodsmart (telenutrition services)	$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/quarter	$75/quarter
Weight Management Program	$100 maximum reimbursement per plan year	$100 maximum reimbursement per plan year
Mom's Meals (home-delivered 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		
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
$75/quarter	$75/quarter	$75/quarter
$100 maximum reimbursement per plan year	$100 maximum reimbursement per plan year	$100 maximum reimbursement per plan year
Covered	Covered	Covered
Covered	Covered	Covered

Important Information and Notes

Important Information and Notes

A plan for life.

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

www.cdphp.com

22-20389 | 0722