# 2024 Summary of Benefits

## Medicare Advantage Plans

**CDPHP® Vital Rx (PPO)**
**CDPHP® Flex Rx (PPO)**
**CDPHP® Flex (PPO)**

January 1, 2024 – December 31, 2024

# 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® Vital Rx (PPO), CDPHP® Flex Rx (PPO) and CDPHP® Flex (PPO)**).

## Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CDPHP® Vital Rx (PPO), CDPHP® Flex Rx (PPO)** and **CDPHP® Flex (PPO)** 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® Vital Rx (PPO), CDPHP® Flex Rx (PPO)** and **CDPHP® Flex (PPO)**
- Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services
- Covered Medical and Hospital Benefits
- Prescription Drug 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 1-866-289-2319 (TTY: 711).

## Things to Know About CDPHP® Vital Rx (PPO), CDPHP® Flex Rx (PPO) and CDPHP® Flex (PPO)

## 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® Vital Rx (PPO), CDPHP® Flex Rx (PPO) and CDPHP® Flex (PPO)**, 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® Vital Rx (PPO), and CDPHP® Flex Rx (PPO),** includes the following counties in New York: Albany, Allegany, Broome, Chemung, Chenango, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Monroe, Montgomery, Oneida, Ontario, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, St. Lawrence, Steuben, Tioga, Warren, Washington and Yates.

The service area for **CDPHP® Flex (PPO)**, 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.

## Which doctors, hospitals, and pharmacies can I use?

**CDPHP® Vital Rx (PPO), CDPHP® Flex Rx (PPO)** and have a network of doctors, hospitals, pharmacies, and other providers. If you use the providers that are not in our network, the plan may not pay for these services.

You must generally use network pharmacies to fill your prescriptions for covered Part D drugs.

You can see our plan's provider and pharmacy directory at our website (www.https://www.cdphp.com/medicare).

Or, call us and we will send you a copy of the provider and pharmacy directories.

## 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.

We cover Part D drugs. 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.

## How will I determine my drug costs?

Our plan groups each medication into one of "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur: Deductible, Initial Coverage, Coverage Gap and Catastrophic Coverage.

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

# 2 SECTION II - SUMMARY OF BENEFITS

| | CDPHP® Vital Rx (PPO) | CDPHP® Flex Rx (PPO) | CDPHP® Flex (PPO) |
|---|---|---|---|
| **MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES** | | | |
| **Monthly Plan Premium** | You do not pay a separate monthly plan premium for CDPHP® Vital Rx (PPO). You must continue to pay your Medicare Part B premium. | $34.80 per month. In addition, you must keep paying your Medicare Part B premiums. | You do not pay a separate monthly plan premium for CDPHP® Flex (PPO). You must continue to pay your Medicare Part B premium. |
| **Deductible** | Medical Deductible: N/A<br>Prescription Drug Deductible: $300 for Tiers 3, 4 and 5. | Medical Deductible: N/A<br>Prescription Drug Deductible: N/A | Medical Deductible: N/A |
| **Maximum Out-of-Pocket Responsibility** | Your yearly limit(s) in this plan:<br>• $7,500 for services you receive from in-network providers.<br>• $11,300 for services you receive from in and out-of-network providers combined.<br>If you reach the limit on out-of-pocket costs, you keep getting covered | Your yearly limit(s) in this plan:<br>• $6,100 for services you receive from in-network providers.<br>• $9,550 for services you receive from in and out-of-network providers combined.<br>If you reach the limit on out-of-pocket costs, you keep getting covered | Your yearly limit(s) in this plan:<br>• $6,100 for services you receive from in-network providers.<br>• $9,550 for services you receive from in and out-of-network providers combined.<br>If you reach the limit on out-of-pocket costs, you keep getting covered |

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| | 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. | 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. | 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. |

| COVERED MEDICAL AND HOSPITAL BENEFITS | | | |
|---|---|---|---|
| **Inpatient Hospital** | **In-Network:**<br>Days 1-4: $360 Copay per day for each admission.<br>Days 5-90: $0 Copay per day.<br>**Out-of-Network:**<br>40% Coinsurance per stay.<br>May require prior authorization. | **In-Network:**<br>Days 1-6: $310 Copay per day for each admission.<br>Days 7-90: $0 Copay per day.<br>**Out-of-Network:**<br>30% Coinsurance per stay.<br>May require prior authorization. | **In-Network:**<br>Days 1-6: $310 Copay per day for each admission.<br>Days 7-90: $0 Copay per day.<br>**Out-of-Network:**<br>30% Coinsurance per stay.<br>May require prior authorization. |
| **Outpatient Hospital** | **In-Network:**<br>Outpatient hospital: $360 Copay.<br>**Out-of-Network:**<br>Outpatient hospital: 40% Coinsurance.<br>May require prior authorization. | **In-Network:**<br>Outpatient hospital: $325 Copay.<br>**Out-of-Network:**<br>Outpatient hospital: 30% Coinsurance.<br>May require prior authorization. | **In-Network:**<br>Outpatient hospital: $325 Copay.<br>**Out-of-Network:**<br>Outpatient hospital: 30% Coinsurance.<br>May require prior authorization. |
| **Ambulatory Surgical Center** | **In-Network:**<br>Ambulatory Surgical Center: $335 Copay. | **In-Network:**<br>Ambulatory Surgical Center: $250 Copay. | **In-Network:**<br>Ambulatory Surgical Center: $250 Copay. |

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| | **<u>Out-of-Network:</u>**<br>Ambulatory Surgical Center: 40% Coinsurance.<br>May require prior authorization. | **<u>Out-of-Network:</u>**<br>Ambulatory Surgical Center: 30% Coinsurance.<br>May require prior authorization. | **<u>Out-of-Network:</u>**<br>Ambulatory Surgical Center: 30% Coinsurance.<br>May require prior authorization. |
| **Doctor's Office Visits** | **<u>In-Network:</u>**<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $45 Copay.<br>**<u>Out-of-Network:</u>**<br>Primary care physician visit: $50 Copay.<br>Specialist visit: 40% Coinsurance.<br>May require prior authorization. | **<u>In-Network:</u>**<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $40 Copay.<br>**<u>Out-of-Network:</u>**<br>Primary care physician visit: $40 Copay.<br>Specialist visit: 30% Coinsurance.<br>May require prior authorization. | **<u>In-Network:</u>**<br>Primary care physician visit: $0 Copay.<br>Specialist visit: $40 Copay.<br>**<u>Out-of-Network:</u>**<br>Primary care physician visit: $40 Copay.<br>Specialist visit: 30% Coinsurance.<br>May require prior authorization. |
| **Preventive Care**<br>***(e.g., flu vaccine, diabetic screenings)*** | **<u>In-Network:</u>**<br>$0 Copay for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>**<u>Out-of-Network:</u>**<br>40% Coinsurance | **<u>In-Network:</u>**<br>$0 Copay for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>**<u>Out-of-Network:</u>**<br>30% Coinsurance | **<u>In-Network:</u>**<br>$0 Copay for all preventive services covered under Original Medicare at zero cost sharing.<br>Any additional preventive services approved by Medicare during the contract year will be covered.<br>**<u>Out-of-Network:</u>**<br>30% Coinsurance |

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| **Emergency Care** | **In-Network and Out-of-Network:**<br>$90 Copay per visit.<br>Worldwide Emergency Coverage: $90 Copay. | **In-Network and Out-of-Network:**<br>$90 Copay per visit.<br>Worldwide Emergency Coverage: $90 Copay. | **In-Network and Out-of-Network:**<br>$90 Copay per visit.<br>Worldwide Emergency Coverage: $90 Copay. |
| **Urgently Needed Services** | **In-Network and Out-of-Network:**<br>$55 Copay per visit.<br>Worldwide Urgent Coverage: $55 Copay. | **In-Network and Out-of-Network:**<br>$55 Copay per visit.<br>Worldwide Urgent Coverage: $55 Copay. | **In-Network and Out-of-Network:**<br>$55 Copay per visit.<br>Worldwide Urgent Coverage: $55 Copay. |
| **Diagnostic Services / Labs/ Imaging** | **In-Network:**<br>Diagnostic tests and procedures: 0%* - 20% Coinsurance.<br>Lab services: $0*- $5 Copay.<br>*Copay waived at preferred providers<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $165 Copay<br>X-rays: $40 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.<br>**Out-of-Network:**<br>Diagnostic tests and procedures: 40% Coinsurance.<br>Lab services: 40% Coinsurance.<br>Diagnostic Radiology Services (such as MRI, | **In-Network:**<br>Diagnostic tests and procedures: $0* - $40 Copay.<br>Lab services: $0*- $5 Copay.<br>*Copay waived at preferred providers<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $135 Copay<br>X-rays: $35 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.<br>**Out-of-Network:**<br>Diagnostic tests and procedures: 30% Coinsurance.<br>Lab services: 30% Coinsurance.<br>Diagnostic Radiology Services (such as MRI, | **In-Network:**<br>Diagnostic tests and procedures: $0* - $40 Copay.<br>Lab services: $0*- $5 Copay.<br>*Copay waived at preferred providers<br>Diagnostic Radiology Services (such as MRI, CAT Scan): $135 Copay<br>X-rays: $35 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance.<br>**Out-of-Network:**<br>Diagnostic tests and procedures: 30% Coinsurance.<br>Lab services: 30% Coinsurance.<br>Diagnostic Radiology Services (such as MRI, |

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| | CAT Scan): 40% Coinsurance.<br>X-rays: 40% Coinsurance.<br>Therapeutic radiology services (such as radiation treatment for cancer): 40% Coinsurance.<br>May require prior authorization. | CAT Scan): 30% Coinsurance.<br>X-rays: $40 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 30% Coinsurance.<br>May require prior authorization. | CAT Scan): 30% Coinsurance.<br>X-rays: $40 Copay.<br>Therapeutic radiology services (such as radiation treatment for cancer): 30% Coinsurance.<br>May require prior authorization. |
| **Hearing Services** | **In-Network:**<br>Exam to diagnose and treat hearing and balance issues: $45 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $45 Copay.<br>Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay.<br>**Out-of-Network:**<br>Exam to diagnose and treat hearing and balance issues: 40% Coinsurance.<br>Routine hearing exam (up to 1 visit(s) every year): 40% Coinsurance. | **In-Network:**<br>Exam to diagnose and treat hearing and balance issues: $45 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $45 Copay.<br>Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay.<br>**Out-of-Network:**<br>Exam to diagnose and treat hearing and balance issues: $45 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $45 Copay. | **In-Network:**<br>Exam to diagnose and treat hearing and balance issues: $45 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $45 Copay.<br>Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay.<br>**Out-of-Network:**<br>Exam to diagnose and treat hearing and balance issues: $45 Copay.<br>Routine hearing exam (up to 1 visit(s) every year): $45 Copay. |
| **Dental Services** | **In-Network and Out-of-Network:**<br>Medicare Covered: $45 Copay.<br>Preventive and restorative dental services: You have a | **In-Network and Out-of-Network:**<br>Medicare Covered: $40 Copay.<br>Preventive and restorative dental services: You have a | **In-Network and Out-of-Network:**<br>Medicare Covered: $40 Copay.<br>Preventive and restorative dental services: You have a |

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| | $850 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider. | $1,000 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider. | $1,000 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:**<br>$0 - $45 Copay.<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$0 - $40 Copay.<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$0 - $40 Copay.<br>**Out-of-Network:**<br>Not Covered |
| **Over-the-Counter (OTC Items)** | **In-Network:**<br>$25/Quarter on a prepaid Benefits Mastercard<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$25/Quarter on a prepaid Benefits Mastercard<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$25/Quarter on a prepaid Benefits Mastercard<br>**Out-of-Network:**<br>Not Covered |
| **Vision Services** | **In-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $45 Copay.<br>Routine eye exam (up to 1 visit(s) every year): $20 Copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 Copay<br>Our plan pays up to $150 every year for eyewear. | **In-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $40 Copay.<br>Routine eye exam (up to 1 visit(s) every year): $20 Copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 Copay<br>Our plan pays up to $175 every year for eyewear. | **In-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $40 Copay.<br>Routine eye exam (up to 1 visit(s) every year): $20 Copay.<br>Eyeglasses or contact lenses after cataract surgery: $0 Copay<br>Our plan pays up to $175 every year for eyewear. |

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| | **Out-of-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 40% Coinsurance.<br>Routine eye exam (up to 1 visit(s) every year): 40% Coinsurance.<br>Eyeglasses or contact lenses after cataract surgery: 40% Coinsurance. | **Out-of-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 30% Coinsurance.<br>Routine eye exam (up to 1 visit(s) every year): 30% Coinsurance.<br>Eyeglasses or contact lenses after cataract surgery: 30% Coinsurance. | **Out-of-Network:**<br>Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): 30% Coinsurance.<br>Routine eye exam (up to 1 visit(s) every year): 30% Coinsurance.<br>Eyeglasses or contact lenses after cataract surgery: 30% Coinsurance. |

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| **Mental Health Care** | **In-Network:**<br>Inpatient Mental Health Care:<br>Days 1-5: $330 Copay per day for each admission.<br>Days 6-90: $0 Copay per day.<br>Outpatient group therapy visit: $40 Copay.<br>Outpatient Individual therapy visit: $40 Copay.<br>**Out-of-Network:**<br>Inpatient Mental Health Care: 40% Coinsurance<br>Outpatient group therapy visit: 40% Coinsurance<br>Outpatient Individual therapy visit: 40% Coinsurance | **In-Network:**<br>Inpatient Mental Health Care:<br>Days 1-5: $300 Copay per day for each admission.<br>Days 6-90: $0 Copay per day.<br>Outpatient group therapy visit: $40 Copay.<br>Outpatient Individual therapy visit: $40 Copay.<br>**Out-of-Network:**<br>Inpatient Mental Health Care: 30% Coinsurance<br>Outpatient group therapy visit: $60 Copay.<br>Outpatient Individual therapy visit: $60 Copay. | **In-Network:**<br>Inpatient Mental Health Care:<br>Days 1-5: $300 Copay per day for each admission.<br>Days 6-90: $0 Copay per day.<br>Outpatient group therapy visit: $40 Copay.<br>Outpatient Individual therapy visit: $40 Copay.<br>**Out-of-Network:**<br>Inpatient Mental Health Care: 30% Coinsurance<br>Outpatient group therapy visit: $60 Copay.<br>Outpatient Individual therapy visit: $60 Copay. |
| **Skilled Nursing Facility (SNF)** | **In-Network:**<br>Days 1-20: $0 Copay per day.<br>Days 21-100: $184 Copay per day.<br>**Out-of-Network:**<br>$0 Copay per stay.<br>40% Coinsurance per stay.<br>May require prior authorization. | **In-Network:**<br>Days 1-20: $0 Copay per day.<br>Days 21-100: $145 Copay per day.<br>**Out-of-Network:**<br>$0 Copay per stay.<br>30% Coinsurance per stay.<br>May require prior authorization. | **In-Network:**<br>Days 1-20: $0 Copay per day.<br>Days 21-100: $145 Copay per day.<br>**Out-of-Network:**<br>$0 Copay per stay.<br>30% Coinsurance per stay.<br>May require prior authorization. |
| **Outpatient Rehabilitation** | **In-Network:**<br>Occupational therapy visit: $30 Copay. | **In-Network:**<br>Occupational therapy visit: $40 Copay. | **In-Network:**<br>Occupational therapy visit: $40 Copay. |

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| | Physical therapy and speech and language therapy visit: $30 Copay.<br>**Out-of-Network:**<br>Occupational therapy visit: 40% Coinsurance.<br>Physical therapy and speech and language therapy visit: 40% Coinsurance. | Physical therapy and speech and language therapy visit: $40 Copay.<br>**Out-of-Network:**<br>Occupational therapy visit: $60 Copay.<br>Physical therapy and speech and language therapy visit: $60 Copay. | Physical therapy and speech and language therapy visit: $40 Copay.<br>**Out-of-Network:**<br>Occupational therapy visit: $60 Copay.<br>Physical therapy and speech and language therapy visit: $60 Copay. |
| **Ambulance** | **In-Network:**<br>Ground Ambulance: $265 Copay.<br>Air Ambulance: $265 Copay.<br>**Out-of-Network:**<br>Ground Ambulance: $265 Copay.<br>Air Ambulance: $265 Copay. | **In-Network:**<br>Ground Ambulance: $255 Copay.<br>Air Ambulance: $255 Copay.<br>**Out-of-Network:**<br>Ground Ambulance: $255 Copay.<br>Air Ambulance: $255 Copay. | **In-Network:**<br>Ground Ambulance: $255 Copay.<br>Air Ambulance: $255 Copay.<br>**Out-of-Network:**<br>Ground Ambulance: $255 Copay.<br>Air Ambulance: $255 Copay. |
| **Transportation** | **In-Network:**<br>$0 Copay<br>No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$0 Copay<br>No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.<br>**Out-of-Network:**<br>Not Covered | **In-Network:**<br>$0 Copay<br>No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.<br>**Out-of-Network:**<br>Not Covered |

<table>
<tr>
<td>Medicare Part B Drugs</td>
<td><u>In-Network:</u><br>For Part B drugs such as chemotherapy drugs: 20% Coinsurance.<br>Other Part B drugs: $35 Copay - 20% Coinsurance.<br><u>Out-of-Network:</u><br>For Part B drugs such as chemotherapy drugs: 40% Coinsurance.<br>Other Part B drugs: 40% Coinsurance.<br>May require prior authorization.</td>
<td><u>In-Network:</u><br>For Part B drugs such as chemotherapy drugs: 20% Coinsurance.<br>Other Part B drugs: $35 Copay - 20% Coinsurance.<br><u>Out-of-Network:</u><br>For Part B drugs such as chemotherapy drugs: 30% Coinsurance.<br>Other Part B drugs: 30% Coinsurance.<br>May require prior authorization.</td>
<td><u>In-Network:</u><br>For Part B drugs such as chemotherapy drugs: 20% Coinsurance.<br>Other Part B drugs: $35 Copay - 20% Coinsurance.<br><u>Out-of-Network:</u><br>For Part B drugs such as chemotherapy drugs: 30% Coinsurance.<br>Other Part B drugs: 30% Coinsurance.<br>May require prior authorization.</td>
</tr>
</table>

<table>
<tr><th colspan="4">PRESCRIPTION DRUG BENEFITS</th></tr>
<tr>
<td>Deductible</td>
<td>Prescription Drug Deductible: $300 for Tiers 3,4 and 5.</td>
<td>Prescription Drug Deductible: $0 Copay.</td>
<td>This plan does not cover Part D prescription drugs.</td>
</tr>
<tr>
<td>Initial Coverage</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>$6 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$20 copay</td></tr>
</table>
</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>$5 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$19 copay</td></tr>
</table>
</td>
<td>This plan does not cover Part D prescription drugs.<br><br>This plan does not cover Part D prescription drugs</td>
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<table>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% coinsurance</td></tr>
</table>
<table>
<tr><th>Tier</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$18 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$60 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$300 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Offered</td></tr>
</table>
<table>
<tr><th colspan="2">Preferred Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 copay</td></tr>
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<td>
<table>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$95 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>$15 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$57 copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$141 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$285 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>Not Offered</td></tr>
</table>
<table>
<tr><th colspan="2">Preferred Retail Cost-Sharing</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 copay</td></tr>
</table>
</td>
<td>This plan does not cover Part D prescription drugs</td>
</tr>
</table>

<table>
<tr>
<td></td>
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<table>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% Coinsurance</td></tr>
</table>
<table>
<tr><th colspan="2">Preferred Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td></tr>
<tr><td>Tier 3 (Preferred Brand)</td><td>$47 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$100 copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>26% coinsurance</td></tr>
</table>
<table>
<tr><th>Tier</th><th>Three-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td></tr>
</table>
</td>
<td>
<table>
<tr><td>Tier 3 (Preferred Brand)</td><td>$44 copay</td></tr>
<tr><td>Tier 4 (Non-Preferred Drug)</td><td>$95 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% Coinsurance</td></tr>
</table>
<table>
<tr><th colspan="2">Preferred Mail Order</th></tr>
<tr><th>Tier</th><th>One-month supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$0 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$0 Copay</td></tr>
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</table>
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</tr>
</table>

| | | | |
|---|---|---|---|
| | Tier 3 (Preferred Brand): $94 copay<br>Tier 4 (Non-Preferred Drug): $250 copay<br>Tier 5 (Specialty Tier): Not Applicable<br><br>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.<br>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. | Tier 3 (Preferred Brand): $88 copay<br>Tier 4 (Non-Preferred Drug): $237.50 copay<br>Tier 5 (Specialty Tier): Not Applicable<br><br>If you reside in a long-term care facility, you pay the same as at a retail pharmacy.<br>You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.<br>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** | The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.<br>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. | The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $5,030.<br>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. | This plan does not cover Part D prescription drugs<br><br>This plan does not cover Part D prescription drugs |

| | | | |
|---|---|---|---|
| **Catastrophic Amount** | After your yearly out-of-pocket drug costs reach $8,000, your prescription drugs are covered in full. | After your yearly out-of-pocket drug costs reach $8,000, your prescription drugs are covered in full. | This plan does not cover Part D prescription drugs |

## 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® Vital Rx (PPO)**, **CDPHP® Flex Rx (PPO)** and **CDPHP® Flex (PPO)** is a Local PPO plan with a Medicare contract. Enrollment in **CDPHP® Vital Rx (PPO)**, **CDPHP® Flex Rx (PPO)** and **CDPHP® Flex (PPO)** 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 CDPHP Universal Benefits, 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.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ 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:** CDPHP Universal Benefits,® Inc.

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