A plan for life.

Summary of Benefits for

CDPHP BASIC Rx (HMO)
CDPHP VALUE RX (HMO)
CDPHP CHOICE (HMO)
CDPHP CHOICE RX (HMO)

January 1, 2016–December 31, 2016
CAPITAL REGION OF NEW YORK STATE

This booklet gives you 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 get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

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 Basic Rx (HMO), CDPHP Value Rx (HMO), CDPHP Choice (HMO) or CDPHP Choice Rx (HMO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CDPHP Basic Rx (HMO), CDPHP Value Rx (HMO), 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 http://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 http://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 Basic Rx (HMO), CDPHP Value Rx (HMO), 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
- 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 1-888-519-4455 and TTY/TDD 1-877-261-1164.

Y0019_16_0237 HMO   CMS Accepted

Things to Know About CDPHP Basic Rx (HMO), CDPHP Value Rx (HMO), CDPHP Choice (HMO) and CDPHP Choice Rx (HMO)

Hours of Operation

- From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time.
- From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time.

CDPHP Basic Rx (HMO), CDPHP Value Rx (HMO), CDPHP Choice (HMO) and CDPHP Choice Rx (HMO) Phone Numbers and Website

- If you are a member of this plan, call toll-free 1-888-248-6522 and TTY/TDD 1-877-261-1164.
- If you are not a member of this plan, call toll-free 1-888-519-4455 and TTY/TDD 1-877-261-1164.
- Our website: http://www.CDPHP.com/medicare

Who can join?

To join **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. Our service area includes the following counties in New York: Albany, Broome, Chenango, Columbia, Delaware, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Warren, and Washington.

Which doctors, hospitals, and pharmacies can I use?

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 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 (http://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*.

- **Our plan members get *all* of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare.** For others, you may pay less.
- **Our plan members also get *more than what is* covered by Original Medicare.** Some of the extra benefits are outlined in this booklet.

Some plans cover Part D drugs. In addition, we cover Part B drugs such as 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, http://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 five "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: Initial Coverage, Coverage Gap, and Catastrophic Coverage.

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
How much is the monthly premium?	$39.50 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	This plan does not have a deductible.
Is there any limit on how much I will pay for my covered services?	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $6,700 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.
Is there a limit on how much the plan will pay?	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

CDPHP is a health plan with a Medicare contract. Enrollment in CDPHP Medicare Choices depends on contract renewal.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
$59.50 per month. In addition, you must keep paying your Medicare Part B premium.	$45.00 per month. In addition, you must keep paying your Medicare Part B premium.	$113.50 per month. In addition, you must keep paying your Medicare Part B premium.
This plan does not have a deductible.	This plan does not have a deductible.	This plan does not have a deductible.
Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $5,500 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.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $4,000 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.	Yes. Like all Medicare health plans, our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $4,000 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.
Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.	Our plan has a coverage limit every year for certain in-network benefits. Contact us for the services that apply.

CDPHP is a health plan with a Medicare contract. Enrollment in CDPHP Medicare Choices depends on contract renewal.

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
COVERED MEDICAL BENEFITS	
Note: **• Services with a [1] may require prior authorization.** **• Services with a [2] may require a referral from your doctor.**	
OUTPATIENT CARE AND SERVICES	
Acupuncture	Not covered
Ambulance[1]	$225 Copay Prior authorization required for non-emergent and/or routine ambulance requests including air ambulance services.
Chiropractic Care[2]	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 Copay
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $0 Copay Preventive dental services: Cleaning (for up to 1 every year): • $0 Copay Dental X-ray(s) (for up to 1 every year): • $0 Copay Fluoride treatment (for up to 1 every year): • $0 Copay Oral exam (for up to 1 every year): • $0 Copay Our plan pays up to $75 every year for preventive dental services. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not covered.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
COVERED MEDICAL BENEFITS		
Note: **• Services with a [1] may require prior authorization.** **• Services with a [2] may require a referral from your doctor.**		
OUTPATIENT CARE AND SERVICES		
Not covered	Not covered	Not covered
$175 Copay Prior authorization required for non-emergent and/or routine ambulance requests including air ambulance services.	$100 Copay Prior authorization required for non-emergent and/or routine ambulance requests including air ambulance services.	$100 Copay Prior authorization required for non-emergent and/or routine ambulance requests including air ambulance services.
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 Copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 Copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $20 Copay
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $0 Copay Preventive dental services: Cleaning (for up to 2 every year): • $0 Copay Dental X-ray(s) (for up to 2 every year): • $0 Copay Fluoride treatment (for up to 2 every year): • $0 Copay Oral exam (for up to 2 every year): • $0 Copay Our plan pays up to $100 every year for preventive dental services. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not covered.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $0 Copay Preventive dental services: Cleaning (for up to 2 every year): • $0 Copay Dental X-ray(s) (for up to 2 every year): • $0 Copay Fluoride treatment (for up to 2 every year): • $0 Copay Oral exam (for up to 2 every year): • $0 Copay Our plan pays up to $125 every year for preventive dental services. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not covered.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • $0 Copay Preventive dental services: Cleaning (for up to 2 every year): • $0 Copay Dental X-ray(s) (for up to 2 every year): • $0 Copay Fluoride treatment (for up to 2 every year): • $0 Copay Oral exam (for up to 2 every year): • $0 Copay Our plan pays up to $125 every year for preventive dental services. You may see any dental provider, whether in- or out-of-network. Periodontal cleanings are not covered.

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Diabetes Supplies and Services	Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost These payments do not apply to your outpatient prescription drug limit. Blood glucose test strips: no copayment (limited to a 30 day supply). Blood glucose monitor: no copayment (limited to one per year from Bayer). Therapeutic shoes and inserts: you pay the lesser of 20% of the cost or $300 maximum per covered item. All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (30 day supply).
Diagnostic Tests, Lab and Radiology Services, and X-Rays ***(Costs for these services may be different if received in an outpatient surgery setting)*** [1, 2]	Diagnostic radiology services (such as MRIs, CT scans): $100 copay Diagnostic tests and procedures: $0–50 Copay, depending on the service Lab services: $0–50 Copay, depending on the service Outpatient X-rays: $50 Copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost $0 copayment at preferred laboratory for Outpatient and diagnostic laboratory services
Doctor's Office Visits [1, 2]	Primary care physician visit: $15 Copay Specialist visit: $50 Copay
Durable Medical Equipment ***(wheelchairs, oxygen, etc.)*** [1]	20% of the cost You pay the lesser of 20% of the allowed amount or $300 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 $500 or more.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost These payments do not apply to your outpatient prescription drug limit. Blood glucose test strips: no copayment (limited to a 30 day supply). Blood glucose monitor: no copayment (limited to one per year from Bayer). Therapeutic shoes and inserts: you pay the lesser of 20% of the cost or $250 maximum per covered item. All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (30 day supply).	Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost These payments do not apply to your outpatient prescription drug limit. Blood glucose test strips: no copayment (limited to a 30 day supply). Blood glucose monitor: no copayment (limited to one per year from Bayer). Therapeutic shoes and inserts: you pay the lesser of 20% of the cost or $250 maximum per covered item. All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (30 day supply).	Diabetes monitoring supplies: 20% of the cost Diabetes self-management training: You pay nothing Therapeutic shoes or inserts: 20% of the cost These payments do not apply to your outpatient prescription drug limit. Blood glucose test strips: no copayment (limited to a 30 day supply). Blood glucose monitor: no copayment (limited to one per year from Bayer). Therapeutic shoes and inserts: you pay the lesser of 20% of the cost or $250 maximum per covered item. All other diabetic supplies: you pay the lesser of 20% of the cost or $10 maximum per covered item (30 day supply).
Diagnostic radiology services (such as MRIs, CT scans): $80 copay Diagnostic tests and procedures: $0–40 Copay, depending on the service Lab services: $0–40 Copay, depending on the service Outpatient X-rays: $40 Copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost $0 copayment at preferred laboratory for Outpatient and diagnostic laboratory services	Diagnostic radiology services (such as MRIs, CT scans): $70 copay Diagnostic tests and procedures: $0–35 Copay, depending on the service Lab services: $0–35 Copay, depending on the service Outpatient X-rays: $35 Copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost $0 copayment at preferred laboratory for Outpatient and diagnostic laboratory services	Diagnostic radiology services (such as MRIs, CT scans): $70 copay Diagnostic tests and procedures: $0–35 Copay, depending on the service Lab services: $0–35 Copay, depending on the service Outpatient X-rays: $35 Copay Therapeutic radiology services (such as radiation treatment for cancer): 20% of the cost $0 copayment at preferred laboratory for Outpatient and diagnostic laboratory services
Primary care physician visit: $25 Copay Specialist visit: $40 Copay	Primary care physician visit: $20 Copay Specialist visit: $35 Copay	Primary care physician visit: $20 Copay Specialist visit: $35 Copay
20% of the cost 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 $500 or more.	20% of the cost 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 $500 or more.	20% of the cost 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 $500 or more.

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Emergency Care	$75 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot Care ***(podiatry services)*** [2]	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $50 Copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: $50 Copay Routine hearing exam (for up to 1 every year): $50 Copay
Home Health Care [1, 2]	You pay nothing.
Mental Health Care [1, 2] *The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.* *There is a190-day lifetime limit for inpatient services in a psychiatric hospital.* *The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.*	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $300 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond Outpatient group therapy visit: $40 Copay Outpatient individual therapy visit: $40 Copay
Outpatient Rehabilitation [1, 2]	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $10 Copay Occupational therapy visit: $40 Copay Physical therapy and speech and language therapy visit: $40 Copay As Medically Necessary

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
$75 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$75 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$75 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.
Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $40 Copay	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
Exam to diagnose and treat hearing and balance issues: $40 Copay Routine hearing exam (for up to 1 every year): $40 Copay	Exam to diagnose and treat hearing and balance issues: $35 Copay Routine hearing exam (for up to 1 every year): $35 Copay	Exam to diagnose and treat hearing and balance issues: $35 Copay Routine hearing exam (for up to 1 every year): $35 Copay
You pay nothing.	You pay nothing.	You pay nothing.
Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $225 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond Outpatient group therapy visit: $40 Copay Outpatient individual therapy visit: $40 Copay	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond Outpatient group therapy visit: $35 Copay Outpatient individual therapy visit: $35 Copay	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond Outpatient group therapy visit: $35 Copay Outpatient individual therapy visit: $35 Copay
Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $10 Copay Occupational therapy visit: $40 Copay Physical therapy and speech and language therapy visit: $40 Copay As Medically Necessary	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $10 Copay Occupational therapy visit: $35 Copay Physical therapy and speech and language therapy visit: $35 Copay As Medically Necessary	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): $10 Copay Occupational therapy visit: $35 Copay Physical therapy and speech and language therapy visit: $35 Copay As Medically Necessary

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Outpatient Substance Abuse	Group therapy visit: $40 Copay Individual therapy visit: $40 Copay
Outpatient Surgery [1, 2]	Ambulatory surgical center: $280 Copay Outpatient hospital: $330 Copay
Over-the-Counter Items	Not Covered
Prosthetic Devices ***(braces, artificial limbs, etc.)*** [1]	Prosthetic devices: • 20% of the cost Related medical supplies: 20% of the cost You pay the lesser of 20% of the allowed amount or $300 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.
Renal Dialysis	$30 Copay In general, out-of-area dialysis services are covered only within the United States.
Transportation [1]	You pay nothing 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.
Urgently Needed Services	$65 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the “Inpatient Hospital Care” section of this booklet for other costs.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Group therapy visit: $40 Copay Individual therapy visit: $40 Copay	Group therapy visit: $35 Copay Individual therapy visit: $35 Copay	Group therapy visit: $35 Copay Individual therapy visit: $35 Copay
Ambulatory surgical center: $175 Copay Outpatient hospital: $225 Copay	Ambulatory surgical center: $125 Copay Outpatient hospital: $175 Copay	Ambulatory surgical center: $125 Copay Outpatient hospital: $175 Copay
Not Covered	Not Covered	Not Covered
Prosthetic devices: • 20% of the cost Related medical supplies: 20% of the cost You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.	Prosthetic devices: • 20% of the cost Related medical supplies: 20% of the cost You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.	Prosthetic devices: • 20% of the cost Related medical supplies: 20% of the cost You pay the lesser of 20% of the allowed amount or $250 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.
$30 Copay In general, out-of-area dialysis services are covered only within the United States.	$30 Copay In general, out-of-area dialysis services are covered only within the United States.	$30 Copay In general, out-of-area dialysis services are covered only within the United States.
You pay nothing 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.	You pay nothing 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.	You pay nothing 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.
$60 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$55 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.	$55 Copay If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for urgent care. See the "Inpatient Hospital Care" section of this booklet for other costs.

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-50 copay, depending on the service Routine eye exam (for up to 1 every year): $50 copay Contact lenses: $0 Copay Eyeglasses (frames and lenses): $0 Copay Eyeglass frames: $0 Copay Eyeglass lenses: $0 Copay Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $50 every year for eyewear.
Preventive Care [1] *(continued on next page)*	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-40 copay, depending on the service Routine eye exam (for up to 1 every year): $40 copay Contact lenses: $0 Copay Eyeglasses (frames and lenses): $0 Copay Eyeglass frames: $0 Copay Eyeglass lenses: $0 Copay Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $50 every year for eyewear.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-35 copay, depending on the service Routine eye exam (for up to 1 every year): $35 copay Contact lenses: $0 Copay Eyeglasses (frames and lenses): $0 Copay Eyeglass frames: $0 Copay Eyeglass lenses: $0 Copay Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $50 every year for eyewear.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-35 copay, depending on the service Routine eye exam (for up to 1 every year): $35 copay Contact lenses: $0 Copay Eyeglasses (frames and lenses): $0 Copay Eyeglass frames: $0 Copay Eyeglass lenses: $0 Copay Eyeglasses or contact lenses after cataract surgery: 20% of the cost Our plan pays up to $50 every year for eyewear.
You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling	You pay nothing Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Preventive Care [1] *(continued from previous page)*	• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE	
Inpatient Hospital Care [1, 2] *The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.*	Our plan covers an unlimited number of days for an inpatient hospital stay. • $330 copay per day for days 1 through 5 • You pay nothing per day for days 6 through 90 • You pay nothing per day for days 91 and beyond
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF) [1, 2] *The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods.*	Our plan covers up to 100 days in a SNF as long as you previously stayed in a hospital for 1 day. • You pay nothing per day for days 1 through 20 • $160 copay per day for days 21 through 100

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	• Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.
You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE		
Our plan covers an unlimited number of days for an inpatient hospital stay. • $225 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond	Our plan covers an unlimited number of days for an inpatient hospital stay. • $175 copay per day for days 1 through 6 • You pay nothing per day for days 7 through 90 • You pay nothing per day for days 91 and beyond
For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Our plan covers up to 100 days in a SNF as long as you previously stayed in a hospital for 1 day. • You pay nothing per day for days 1 through 20 • $110 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF as long as you previously stayed in a hospital for 1 day. • You pay nothing per day for days 1 through 20 • $90 copay per day for days 21 through 100	Our plan covers up to 100 days in a SNF as long as you previously stayed in a hospital for 1 day. • You pay nothing per day for days 1 through 20 • $90 copay per day for days 21 through 100

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemo-therapy drugs[1]: 20% of the cost Other Part B drugs[1]: 20% of the cost
Initial Coverage	You pay the following until your total yearly drug costs reach $3,310. 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.
Standard Retail Cost-Sharing	

Tier	One Month Supply	Three Month Supply
Tier 1 (Preferred Generic)	$2 Copay	$6 Copay
Tier 2 (Generic)	$15 Copay	$45 Copay
Tier 3 (Preferred Brand)	$45 Copay	$135 Copay
Tier 4 (Non-Preferred Brand)	$95 Copay	$285 Copay
Tier 5 (Specialty Tier)	33% of the cost	Not Offered

<table>
<tr><th>CDPHP Value Rx (HMO)</th><th>CDPHP Choice (HMO)</th><th>CDPHP Choice Rx (HMO)</th></tr>
<tr><td colspan="3">PRESCRIPTION DRUG BENEFITS</td></tr>
<tr><td>For Part B drugs such as chemo-therapy drugs[1]: 20% of the cost
Other Part B drugs[1]: 20% of the cost</td><td>For Part B drugs such as chemo-therapy drugs[1]: 20% of the cost
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Other Part B drugs[1]: 20% of the cost</td></tr>
<tr><td>You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td><td>Our plan does not cover Part D prescription drug.</td><td>You pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan.
You may get your drugs at network retail pharmacies and mail order pharmacies.</td></tr>
<tr><td>
<table>
<tr><th>Tier</th><th>One Month Supply</th><th>Three Month Supply</th></tr>
<tr><td>Tier 1 (Preferred Generic)</td><td>$2 Copay</td><td>$6 Copay</td></tr>
<tr><td>Tier 2 (Generic)</td><td>$12 Copay</td><td>$36 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 Brand)</td><td>$95 Copay</td><td>$285 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr>
</table>
</td><td></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>$11 Copay</td><td>$33 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 Brand)</td><td>$95 Copay</td><td>$285 Copay</td></tr>
<tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr>
</table>
</td></tr>
</table>

Summary of Benefits January 1, 2016–December 31, 2016

Benefit Category	Basic Rx (HMO)
Standard Mail Order Cost-Sharing	<table><tr><th>Tier</th><th>One Month Supply</th><th>Three Month Supply</th></tr><tr><td>Tier 1 (Preferred Generic)</td><td>$2 Copay</td><td>$4 Copay</td></tr><tr><td>Tier 2 (Generic)</td><td>$15 Copay</td><td>$30 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 Brand)</td><td>$95 Copay</td><td>$285 Copay</td></tr><tr><td>Tier 5 (Specialty Tier)</td><td>33% of the cost</td><td>Not Offered</td></tr></table> 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.
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 $3,310. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, 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 $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

CDPHP Value Rx (HMO)	CDPHP Choice (HMO)	CDPHP Choice Rx (HMO)
(see table below)		(see table below)

CDPHP Value Rx (HMO)

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$2 Copay	$4 Copay
Tier 2 (Generic)	$12 Copay	$24 Copay
Tier 3 (Preferred Brand)	$45 Copay	$90 Copay
Tier 4 (Non-Preferred Brand)	$95 Copay	$237.50 Copay
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.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

CDPHP Choice Rx (HMO)

Tier	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0 Copay	$0 Copay
Tier 2 (Generic)	$11 Copay	$22 Copay
Tier 3 (Preferred Brand)	$45 Copay	$90 Copay
Tier 4 (Non-Preferred Brand)	$95 Copay	$237.50 Copay
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.

You may get drugs from an out-of-network pharmacy, but may pay more than you pay at an in-network pharmacy.

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 $3,310. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total $4,850, 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 $3,310. After you enter the coverage gap, you pay 45% of the plan’s cost for covered brand name drugs and 58% of the plan’s cost for covered generic drugs until your costs total $4,850, 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 $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.		After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of: • 5% of the cost, or • $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

Notes/Important Information

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A plan for life.