A plan for life.

Introduction to the Summary of Benefits Report for

CDPHP CLASSIC (PPO)
CDPHP CORE RX (PPO)
CDPHP CLASSIC RX (PPO)
CDPHP PRIME RX (PPO)

January 1, 2015—December 31, 2015
CAPITAL, CENTRAL, SOUTHERN TIER, HUDSON VALLEY, NY

SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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 Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) or CDPHP Prime Rx (PPO)**).

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CDPHP Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) and CDPHP Prime Rx (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 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 Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) and CDPHP Prime Rx (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 call toll-free (888)-519-4455 and TTY/TDD (877)-261-1164.

Things to Know About CDPHP Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) and CDPHP Prime Rx (PPO)

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 Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) and CDPHP Prime Rx (PPO) Phone Numbers and Website

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

Who can join?

To join **CDPHP Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) or CDPHP Prime Rx (PPO),** 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, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington.

Which doctors, hospitals, and pharmacies can I use?

CDPHP Classic (PPO), CDPHP Classic Rx (PPO), CDPHP Core Rx (PPO) and CDPHP Prime Rx (PPO) has a network of doctors, hospitals, pharmacies, and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network.

- 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, 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.

If you have any questions about our plan's benefits or costs, please contact CDPHP Medicare Choices for details.

SECTION II - SUMMARY OF BENEFITS
Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

Benefit Category	CDPHP Classic (PPO)
How much is the monthly premium?	$138.00 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: • $4,000 for services you receive from in-network providers. • $6,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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.
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 Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
$194.50 per month. In addition, you must keep paying your Medicare Part B premium.	$134.50 per month. In addition, you must keep paying your Medicare Part B premium.	$276.50 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: • $4,000 for services you receive from in-network providers. • $6,000 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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: • $4,250 for services you receive from in-network providers. • $6,250 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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: • $3,750 for services you receive from in-network providers. • $5,750 for services you receive from any provider. Your limit for services received from in-network providers will count toward this limit. 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.

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SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
COVERED MEDICAL AND HOSPITAL 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 and Other Alternative Therapies	Not covered
Ambulance[1]	• In-network: $150 copay • Out-of-network: $200 copay
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: You pay nothing • Out-of-network: You pay nothing Preventive dental services: Cleaning (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Dental x-ray(s) (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Fluoride treatment (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Not covered	Not covered	Not covered
• In-network: $150 copay • Out-of-network: $200 copay	• In-network: $200 copay • Out-of-network: $250 copay	• In-network: $100 copay • Out-of-network: $200 copay
Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): • In-network: $20 copay • Out-of-network: $20 copay
Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: You pay nothing • Out-of-network: You pay nothing	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: You pay nothing • Out-of-network: You pay nothing	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): • In-network: You pay nothing • Out-of-network: You pay nothing
Preventive dental services: Cleaning (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Preventive dental services: Cleaning (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Preventive dental services: Cleaning (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing
Dental x-ray(s) (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Dental x-ray(s) (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Dental x-ray(s) (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing
Fluoride treatment (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Fluoride treatment (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing	Fluoride treatment (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Dental Services *(continued)*	Oral exam (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $250 every year for preventive dental services from any provider.
Diabetes Supplies and Services	Diabetes monitoring supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 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 $200 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).

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Oral exam (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $250 every year for preventive dental services from any provider.	Oral exam (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $100 every year for preventive dental services from any provider.	Oral exam (for up to 2 every year): • In-network: You pay nothing • Out-of-network: You pay nothing Our plan pays up to $400 every year for preventive dental services from any provider.
Diabetes monitoring supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 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 $200 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: • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 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).	Diabetes monitoring supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost Diabetes self-management training: • In-network: You pay nothing • Out-of-network: You pay nothing Therapeutic shoes or inserts: • In-network: 20% of the cost • Out-of-network: 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 $200 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).

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Diagnostic Tests, Lab and Radiology Services, and X-Rays[1,2]	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $60 copay • Out-of-network: $60 copay Diagnostic tests and procedures: • In-network: You pay nothing • Out-of-network: $50 copay Lab services: • In-network: You pay nothing • Out-of-network: $50 copay Outpatient x-rays: • In-network: $60 copay • Out-of-network: $60 copay Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $60 copay • Out-of-network: $60 copay
Doctor's Office Visits	Primary care physician visit: • In-network: $20 copay • Out-of-network: $40 copay Specialist visit: • In-network: $30 copay • Out-of-network: $50 copay

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Diagnostic radiology services (such as MRIs, CT scans): • In-network: $60 copay • Out-of-network: $60 copay	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $60 copay • Out-of-network: $60 copay	Diagnostic radiology services (such as MRIs, CT scans): • In-network: $60 copay • Out-of-network: $60 copay
Diagnostic tests and procedures: • In-network: You pay nothing • Out-of-network: $50 copay	Diagnostic tests and procedures: • In-network: You pay nothing • Out-of-network: $60 copay	Diagnostic tests and procedures: • In-network: You pay nothing • Out-of-network: $20 copay
Lab services: • In-network: You pay nothing • Out-of-network: $50 copay	Lab services: • In-network: You pay nothing • Out-of-network: $60 copay	Lab services: • In-network: You pay nothing • Out-of-network: $20 copay
Outpatient x-rays: • In-network: $60 copay • Out-of-network: $60 copay	Outpatient x-rays: • In-network: $60 copay • Out-of-network: $60 copay	Outpatient x-rays: • In-network: $60 copay • Out-of-network: $60 copay
Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $60 copay • Out-of-network: $60 copay	Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $60 copay • Out-of-network: $60 copay	Therapeutic radiology services (such as radiation treatment for cancer): • In-network: $60 copay • Out-of-network: $60 copay
Primary care physician visit: • In-network: $20 copay • Out-of-network: $40 copay	Primary care physician visit: • In-network: $25 copay • Out-of-network: $45 copay	Primary care physician visit: • In-network: $15 copay • Out-of-network: $35 copay
Specialist visit: • In-network: $30 copay • Out-of-network: $50 copay	Specialist visit: • In-network: $40 copay • Out-of-network: $60 copay	Specialist visit: • In-network: $20 copay • Out-of-network: $40 copay

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*[1]	• In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 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.
Emergency Care	$65 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)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $30 copay • Out-of-network: $50 copay
Hearing Services	Exam to diagnose and treat hearing and balance issues: • In-network: $30 copay • Out-of-network: $50 copay Routine hearing exam (for up to 1 every year): • In-network: $30 copay • Out-of-network: $50 copay Hearing aids and hearing aid repairs are not covered.
Home Health Care[1,2]	• In-network: You pay nothing • Out-of-network: You pay nothing

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
• In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 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.	• In-network: 20% of the cost • Out-of-network: 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.	• In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 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.
$65 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.	$65 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.	$65 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: • In-network: $30 copay • Out-of-network: $50 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $40 copay • Out-of-network: $60 copay	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: • In-network: $20 copay • Out-of-network: $40 copay
Exam to diagnose and treat hearing and balance issues: • In-network: $30 copay • Out-of-network: $50 copay Routine hearing exam (for up to 1 every year): • In-network: $30 copay • Out-of-network: $50 copay Hearing aids and hearing aid repairs are not covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $40 copay • Out-of-network: $60 copay Routine hearing exam (for up to 1 every year): • In-network: $40 copay • Out-of-network: $60 copay Hearing aids and hearing aid repairs are not covered.	Exam to diagnose and treat hearing and balance issues: • In-network: $20 copay • Out-of-network: $40 copay Routine hearing exam (for up to 1 every year): • In-network: $20 copay • Out-of-network: $40 copay Hearing aids and hearing aid repairs are not covered.
• In-network: You pay nothing • Out-of-network: You pay nothing	• In-network: You pay nothing • Out-of-network: You pay nothing	• In-network: You pay nothing • Out-of-network: You pay nothing

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Mental Health Care[1,2]	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $600 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,200 copay per stay Outpatient group therapy visit: • In-network: $30 copay • Out-of-network: $40 copay Outpatient individual therapy visit: • In-network: $30 copay • Out-of-network: $40 copay
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay Occupational therapy visit: • In-network: $30 copay • Out-of-network: $40 copay Physical therapy and speech and language therapy visit: • In-network: $30 copay • Out-of-network: $40 copay

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $600 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,200 copay per stay	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $750 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,500 copay per stay	Inpatient visit: Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $400 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,000 copay per stay
Outpatient group therapy visit: • In-network: $30 copay • Out-of-network: $40 copay	Outpatient group therapy visit: • In-network: $40 copay • Out-of-network: $40 copay	Outpatient group therapy visit: • In-network: $20 copay • Out-of-network: $40 copay
Outpatient individual therapy visit: • In-network: $30 copay • Out-of-network: $40 copay	Outpatient individual therapy visit: • In-network: $40 copay • Out-of-network: $40 copay	Outpatient individual therapy visit: • In-network: $20 copay • Out-of-network: $40 copay
Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): • In-network: $10 copay • Out-of-network: $10 copay
Occupational therapy visit: • In-network: $30 copay • Out-of-network: $40 copay	Occupational therapy visit: • In-network: $40 copay • Out-of-network: $40 copay	Occupational therapy visit: • In-network: $20 copay • Out-of-network: $40 copay
Physical therapy and speech and language therapy visit: • In-network: $30 copay • Out-of-network: $40 copay	Physical therapy and speech and language therapy visit: • In-network: $40 copay • Out-of-network: $40 copay	Physical therapy and speech and language therapy visit: • In-network: $20 copay • Out-of-network: $40 copay

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Outpatient Substance Abuse	Group therapy visit: • In-network: $30 copay • Out-of-network: $40 copay Individual therapy visit: • In-network: $30 copay • Out-of-network: $40 copay
Outpatient Surgery	Ambulatory surgical center: • In-network: $125 copay • Out-of-network: $175 copay Outpatient hospital: • In-network: $175 copay • Out-of-network: $225 copay
Over-the-Counter Items	Not Covered
Prosthetic Devices *(braces, artificial limbs, etc.)*[1]	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.
Renal Dialysis	• In-network: $30 copay • Out-of-network: $30 copay In general, out-of-area dialysis services are covered only within the United States.

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Group therapy visit: • In-network: $30 copay • Out-of-network: $40 copay Individual therapy visit: • In-network: $30 copay • Out-of-network: $40 copay	Group therapy visit: • In-network: $40 copay • Out-of-network: $40 copay Individual therapy visit: • In-network: $40 copay • Out-of-network: $40 copay	Group therapy visit: • In-network: $20 copay • Out-of-network: $40 copay Individual therapy visit: • In-network: $20 copay • Out-of-network: $40 copay
Ambulatory surgical center: • In-network: $125 copay • Out-of-network: $175 copay Outpatient hospital: • In-network: $175 copay • Out-of-network: $225 copay	Ambulatory surgical center: • In-network: $150 copay • Out-of-network: $200 copay Outpatient hospital: • In-network: $200 copay • Out-of-network: $250 copay	Ambulatory surgical center: • In-network: $100 copay • Out-of-network: $150 copay Outpatient hospital: • In-network: $150 copay • Out-of-network: $200 copay
Not Covered	Not Covered	Not Covered
Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 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.	Prosthetic devices: • In-network: 20% of the cost • Out-of-network: 20% of the cost Related medical supplies: • In-network: 20% of the cost • Out-of-network: 20% of the cost You pay the lesser of 20% of the allowed amount or $200 maximum per covered item. Prior authorization is required for all foot orthotics. Prior authorization is required for all therapeutic shoes.
• In-network: $30 copay • Out-of-network: $30 copay In general, out-of-area dialysis services are covered only within the United States.	• In-network: $30 copay • Out-of-network: $30 copay In general, out-of-area dialysis services are covered only within the United States.	• In-network: $20 copay • Out-of-network: $30 copay In general, out-of-area dialysis services are covered only within the United States.

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Transportation[1]	• In-network: You pay nothing • Out-of-network: 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.
Urgent Care	$35 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.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $30 copay • Out-of-network: $0-50 copay, depending on the service Routine eye exam (for up to 1 every year): • In-network: $0-30 copay, depending on the service • Out-of-network: $0-50 copay, depending on the service Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
• In-network: You pay nothing • Out-of-network: 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.	• In-network: You pay nothing • Out-of-network: 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.	• In-network: You pay nothing • Out-of-network: 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.
$35 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.	$35 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.	$35 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.
Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $30 copay • Out-of-network: $0-50 copay, depending on the service Routine eye exam (for up to 1 every year): • In-network: $0-30 copay, depending on the service • Out-of-network: $0-50 copay, depending on the service Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $40 copay • Out-of-network: $0-60 copay, depending on the service Routine eye exam (for up to 1 every year): • In-network: $0-40 copay, depending on the service • Out-of-network: $0-60 copay, depending on the service Eyeglasses or contact lenses after cataract surgery: • In-network: 20% of the cost • Out-of-network: 20% of the cost Glaucoma test = $0 copayment	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): • In-network: $20 copay • Out-of-network: $0-40 copay, depending on the service Routine eye exam (for up to 1 every year): • In-network: $0-20 copay, depending on the service • Out-of-network: $0-40 copay, depending on the service Contact lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses (frames and lenses): • In-network: You pay nothing • Out-of-network: You pay nothing

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Vision Services *(continued)*	Eyeglass frames: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglass lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: 20% of the cost • Out-of-network: 20% of the cost Our plan pays up to $100 every year for eyewear from any provider. Glaucoma test = $0 copayment
Preventive Care	In-network: You pay nothing Out-of-network: 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Eyeglass frames: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglass lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: 20% of the cost • Out-of-network: 20% of the cost Our plan pays up to $100 every year for eyewear from any provider. Glaucoma test = $0 copayment		Eyeglass frames: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglass lenses: • In-network: You pay nothing • Out-of-network: You pay nothing Eyeglasses or contact lenses after cataract surgery: • In-network: 20% of the cost • Out-of-network: 20% of the cost Our plan pays up to $150 every year for eyewear from any provider. Glaucoma test = $0 copayment
In-network: You pay nothing Out-of-network: 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings	In-network: You pay nothing Out-of-network: 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings	In-network: You pay nothing Out-of-network: 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 • Colonoscopy • Colorectal cancer screenings • Depression screening • Diabetes screenings

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
OUTPATIENT CARE AND SERVICES *(continued)*	
Preventive Care *(continued)*	• Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • 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.
INPATIENT CARE	
Inpatient Hospital Care[1,2]	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $600 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,200 copay per stay
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
• Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • 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.	• Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • 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.	• Fecal occult blood test • Flexible sigmoidoscopy • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • 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.	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.	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.
Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $600 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,200 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $750 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,500 copay per stay	Our plan covers an unlimited number of days for an inpatient hospital stay. • In-network: $400 copay per stay • You pay nothing per day for days 91 and beyond • Out-of-network: $1,000 copay per stay
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.

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
INTPATIENT CARE *(continued)*	
Skilled Nursing Facility (SNF)[1,2]	Our plan covers up to 100 days in a SNF. • In-network: – $0 copay per day for days 1 through 20 – $90 copay per day for days 21 through 100 • Out-of-network: – You pay nothing per day for days 1 through 20 – $150 copay per day for days 21 through 100 Please note, custodial care and long-term care services are not covered.
PRESCRIPTION DRUG BENEFITS	
How much do I pay?	For Part B drugs such as chemotherapy drugs[1]: • In-network: $35 copay – Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost – Out-of-network: 20% of the cost
Initial Coverage	Our plan does not cover Part D prescription drug.

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
Our plan covers up to 100 days in a SNF. • In-network: – $0 copay per day for days 1 through 20 – $90 copay per day for days 21 through 100 • Out-of-network: – You pay nothing per day for days 1 through 20 – $150 copay per day for days 21 through 100 Please note, custodial care and long-term care services are not covered.	Our plan covers up to 100 days in a SNF. • In-network: – $0 copay per day for days 1 through 20 – $110 copay per day for days 21 through 100 • Out-of-network: – You pay nothing per day for days 1 through 20 – $150 copay per day for days 21 through 100 Please note, custodial care and long-term care services are not covered.	Our plan covers up to 100 days in a SNF. • In-network: – $0 copay per day for days 1 through 20 – $75 copay per day for days 21 through 100 • Out-of-network: – You pay nothing per day for days 1 through 20 – $125 copay per day for days 21 through 100 Please note, custodial care and long-term care services are not covered.
For Part B drugs such as chemotherapy drugs[1]: • In-network: $35 copay – Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost – Out-of-network: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: • In-network: $35 copay – Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost – Out-of-network: 20% of the cost	For Part B drugs such as chemotherapy drugs[1]: • In-network: $35 copay – Out-of-network: 20% of the cost Other Part B drugs[1]: • In-network: 20% of the cost – Out-of-network: 20% of the cost
You pay the following until your total yearly drug costs reach $2,960. 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.	You pay the following until your total yearly drug costs reach $2,960. 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.	You pay the following until your total yearly drug costs reach $2,960. 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.

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
PRESCRIPTION DRUG BENEFITS ***(continued)***	
Standard Retail Cost-Sharing	
Standard Mail Order Cost-Sharing	

CDPHP Classic Rx (PPO)			CDPHP Core Rx (PPO)			CDPHP Prime Rx (PPO)		
Tier	**One Month Supply**	**Three Month Supply**	**Tier**	**One Month Supply**	**Three Month Supply**	**Tier**	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0	$0	Tier 1 (Preferred Generic)	$0	$0	Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Non-Preferred Generic)	$10 copay	$30 copay	Tier 2 (Non-Preferred Generic)	$12 copay	$36 copay	Tier 2 (Non-Preferred Generic)	$8 copay	$24 copay
Tier 3 (Preferred Brand)	$40 copay	$120 copay	Tier 3 (Preferred Brand)	$45 copay	$135 copay	Tier 3 (Preferred Brand)	$40 copay	$120 copay
Tier 4 (Non-Preferred Brand)	$95 copay	$285 copay	Tier 4 (Non-Preferred Brand)	$95 copay	$285 copay	Tier 4 (Non-Preferred Brand)	$80 copay	$240 copay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Tier 5 (Specialty Tier)	30% of the cost	Not Offered
Tier	**One Month Supply**	**Three Month Supply**	**Tier**	**One Month Supply**	**Three Month Supply**	**Tier**	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	$0	$0	Tier 1 (Preferred Generic)	$0	$0	Tier 1 (Preferred Generic)	$0	$0
Tier 2 (Non-Preferred Generic)	$10 copay	$20 copay	Tier 2 (Non-Preferred Generic)	$12 copay	$24 copay	Tier 2 (Non-Preferred Generic)	$8 copay	$16 copay
Tier 3 (Preferred Brand)	$40 copay	$80 copay	Tier 3 (Preferred Brand)	$45 copay	$90 copay	Tier 3 (Preferred Brand)	$40 copay	$80 copay
Tier 4 (Non-Preferred Brand)	$95 copay	$237.50 copay	Tier 4 (Non-Preferred Brand)	$95 copay	$237.50 copay	Tier 4 (Non-Preferred Brand)	$80 copay	$200 copay
Tier 5 (Specialty Tier)	30% of the cost	Not Offered	Tier 5 (Specialty Tier)	33% of the cost	Not Offered	Tier 5 (Specialty Tier)	30% 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.			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.			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.		

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
PRESCRIPTION DRUG BENEFITS ***(continued)***	
Coverage Gap	
Standard Retail Cost-Sharing	

CDPHP Classic Rx (PPO)	CDPHP Core Rx (PPO)	CDPHP Prime Rx (PPO)
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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.	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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, 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 $2,960. After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 65% of the plan's cost for covered generic drugs until your costs total $4,700, which is the end of the coverage gap. Not everyone will enter the coverage gap. Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Tier	Drugs Covered	One Month Supply	Three Month Supply
Tier 1 (Preferred Generic)	All	$0	$0
Tier 2 (Non-Preferred Generic)	All	$10 Copay	$30 Copay

Tier	Drugs Covered	One Month Supply	Three Month Supply
Tier 1 (Preferred Generic)	All	$0	$0
Tier 2 (Non-Preferred Generic)	All	$8 Copay	$24 Copay

SUMMARY OF BENEFITS	
Benefit Category	**CDPHP Classic (PPO)**
PRESCRIPTION DRUG BENEFITS ***(continued)***	
Standard Mail Order Cost-Sharing	
Catastrophic Coverage	

CDPHP Classic Rx (PPO)				CDPHP Core Rx (PPO)				CDPHP Prime Rx (PPO)			
Tier	**Drugs Covered**	**One Month Supply**	**Three Month Supply**		**Tier**	**Drugs Covered**	**One Month Supply**	**Three Month Supply**	**Tier**	**Drugs Covered**	**One Month Supply**	**Three Month Supply**
Tier 1 (Preferred Generic)	All	$0	$0		Tier 1 (Preferred Generic)	All	$0	$0	Tier 1 (Preferred Generic)	All	$0	$0
Tier 2 (Non-Preferred Generic)	All	$10 Copay	$20 Copay		Tier 2 (Non-Preferred Generic)	All	$8 Copay	$16 Copay	Tier 2 (Non-Preferred Generic)	All	$8 Copay	$16 Copay
After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 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 $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 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 $4,700, you pay the greater of: • 5% of the cost, or • $2.65 copay for generic (including brand drugs treated as generic) and a $6.60 copayment for all other drugs.			