2025 Summary of Benefits

Medicare Advantage Plans with Part D Prescription Drug Coverage

CDPHP® Focus (PPO)
CDPHP® Vital Rx (PPO)
CDPHP® Complete Rx (PPO)

January 1, 2025 – December 31, 2025

1 SECTION I - INTRODUCTION TO SUMMARY OF BENEFITS

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

You have choices about how to get your Medicare benefits

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

Tips for comparing your Medicare choices

This Summary of Benefits booklet gives you a summary of what **CDPHP Focus (PPO), CDPHP Vital Rx (PPO)** and **CDPHP Complete 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 www.medicare.gov.
- If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Sections in this booklet

- Things to Know About **CDPHP Focus (PPO), CDPHP Vital Rx (PPO)** and **CDPHP Complete 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 1-866-289-2319 (TTY: 711).

Things to Know About CDPHP Focus (PPO), CDPHP Vital Rx (PPO) and CDPHP Complete Rx (PPO)

Hours of Operation & Contact Information

- From October 1 to March 31 we're open 8 a.m. – 8 p.m., 7 days a week.
- From April 1 to September 30, we're open 8 a.m. – 8 p.m., Monday through Friday.
- If you are a member of this plan, call us at 1-888-248-6522, TTY: 711.
- If you are not a member of this plan, call us at 1-888-519-4455, TTY: 711.
- Our website: www.https://www.cdphp.com/medicare.

Who can join?

To join **CDPHP Focus (PPO), CDPHP Vital Rx (PPO)** or **CDPHP Complete Rx (PPO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and you must live in our service area. The service area **for CDPHP Focus (PPO)**, **CDPHP Vital Rx (PPO)** and **CDPHP Complete Rx (PPO)** includes the following counties in New York: Albany, Broome, Chenango, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, St. Lawrence, Tioga, Warren and Washington.

Which doctors, hospitals, and pharmacies can I use?

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

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

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

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

What do we cover?

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

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

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

How will I determine my drug costs?

Our plan groups each medication into one of 5 "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 and Catastrophic Coverage.

If you have any questions about this plan's benefits or costs, please contact CDPHP Medicare Advantage at 1-888-248-6522, TTY 711.

2 SECTION II - SUMMARY OF BENEFITS

	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES			
Monthly Plan Premium	There is no separate monthly plan premium. You must continue to pay your Medicare Part B premium.	There is no separate monthly plan premium. You must continue to pay your Medicare Part B premium.	$70.00 per month. In addition, you must keep paying your Medicare Part B premiums.
Deductible	Medical Deductible: N/A	Medical Deductible: N/A	Medical Deductible: N/A
Maximum Out-of-Pocket Responsibility	Your yearly limit(s) in this plan: • $6,100 for services you receive from in-network providers. • $9,550 for services you receive from in and out-of-network providers combined. 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.	Your yearly limit(s) in this plan: • $6,750 for services you receive from in-network providers. • $10,100 for services you receive from in and out-of-network providers combined. 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.	Your yearly limit(s) in this plan: • $6,000 for services you receive from in-network providers. • $10,100 for services you receive from in and out-of-network providers combined. 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.

COVERED MEDICAL AND HOSPITAL BENEFITS			
Benefits/Services	**CDPHP Focus (PPO)**	**CDPHP Vital Rx (PPO)**	**CDPHP Complete Rx (PPO)**
Inpatient Hospital	**In-Network:** Days 1-6: $310 Copay per day for each admission. Days 7-90: $0 Copay per day. **Out-of-Network:** 30% Coinsurance per stay. May require prior authorization.	**In-Network:** Days 1-5: $500 Copay per day for each admission. Days 6-90: $0 Copay per day. **Out-of-Network:** 40% Coinsurance per stay. May require prior authorization.	**In-Network:** Days 1-6: $310 Copay per day for each admission. Days 7-90: $0 Copay per day. **Out-of-Network:** 30% Coinsurance per stay. May require prior authorization.
Outpatient Hospital	**In-Network:** Outpatient hospital: $325 Copay. **Out-of-Network:** Outpatient hospital: 30% Coinsurance. May require prior authorization.	**In-Network:** Outpatient hospital: $360 Copay. **Out-of-Network:** Outpatient hospital: 40% Coinsurance. May require prior authorization.	**In-Network:** Outpatient hospital: $325 Copay. **Out-of-Network:** Outpatient hospital: 30% Coinsurance. May require prior authorization.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Ambulatory Surgical Center	**In-Network:** Ambulatory Surgical Center: $250 Copay. **Out-of-Network:** Ambulatory Surgical Center: 30% Coinsurance. May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $335 Copay. **Out-of-Network:** Ambulatory Surgical Center: 40% Coinsurance. May require prior authorization.	**In-Network:** Ambulatory Surgical Center: $275 Copay. **Out-of-Network:** Ambulatory Surgical Center: 30% Coinsurance. May require prior authorization.
Doctor's Office Visits	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $40 Copay. **Out-of-Network:** Primary care physician visit: $40 Copay. Specialist visit: 30% Coinsurance. May require prior authorization.	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $45 Copay. **Out-of-Network:** Primary care physician visit: $50 Copay. Specialist visit: 40% Coinsurance. May require prior authorization.	**In-Network:** Primary care physician visit: $0 Copay. Specialist visit: $40 Copay. **Out-of-Network:** Primary care physician visit: $40 Copay. Specialist visit: 30% Coinsurance. May require prior authorization.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Preventive Care ***(e.g., flu vaccine, diabetic screenings)***	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 30% Coinsurance	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 40% Coinsurance	**In-Network:** $0 Copay for all preventive services covered under Original Medicare at zero cost sharing. Any additional preventive services approved by Medicare during the contract year will be covered. **Out-of-Network:** 30% Coinsurance
Emergency Care	**In-Network and Out-of-Network:** $90 Copay per visit. Worldwide Emergency Coverage: $90 Copay.	**In-Network and Out-of-Network:** $120 Copay per visit. Worldwide Emergency Coverage: $120 Copay.	**In-Network and Out-of-Network:** $120 Copay per visit. Worldwide Emergency Coverage: $120 Copay.
Urgently Needed Services	**In-Network and Out-of-Network:** $55 Copay per visit. Worldwide Urgent Coverage: $55 Copay.	**In-Network and Out-of-Network:** $55 Copay per visit. Worldwide Urgent Coverage: $55 Copay.	**In-Network and Out-of-Network:** $55 Copay per visit. Worldwide Urgent Coverage: $55 Copay.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Diagnostic Services / Labs/ Imaging	**In-Network:** Diagnostic tests and procedures: $0* - $40 Copay. Lab services: $0* - $5 Copay. *Copay/Coinsurance waived at preferred providers. Diagnostic Radiology Services (such as MRI, CAT Scan): $135 Copay X-rays: $35 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. **Out-of-Network:** Diagnostic tests and procedures: 30% Coinsurance. Lab services: 30% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 30% Coinsurance. X-rays: $40 Copay. Therapeutic radiology services (such as radiation treatment for	**In-Network:** Diagnostic tests and procedures: 0%* - 20% Coinsurance. Lab services: $0* - $5 Copay. *Copay/Coinsurance waived at preferred providers. Diagnostic Radiology Services (such as MRI, CAT Scan): $175 Copay X-rays: $10 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. **Out-of-Network:** Diagnostic tests and procedures: 40% Coinsurance. Lab services: 40% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 40% Coinsurance. X-rays: 40% Coinsurance. Therapeutic radiology services (such as radiation treatment for	**In-Network:** Diagnostic tests and procedures: 0%* - 20% Coinsurance. Lab services: $0* - $5 Copay. *Copay/Coinsurance waived at preferred providers. Diagnostic Radiology Services (such as MRI, CAT Scan): $135 Copay X-rays: $5 Copay. Therapeutic radiology services (such as radiation treatment for cancer): 20% Coinsurance. **Out-of-Network:** Diagnostic tests and procedures: 30% Coinsurance. Lab services: 30% Coinsurance. Diagnostic Radiology Services (such as MRI, CAT Scan): 30% Coinsurance. X-rays: $40 Copay. Therapeutic radiology services (such as radiation treatment for

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
	cancer): 30% Coinsurance. May require prior authorization.	cancer): 40% Coinsurance. May require prior authorization.	cancer): 30% Coinsurance. May require prior authorization.
Hearing Services	**In-Network:** Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 - $45 Copay. Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam (up to 1 visit(s) every year): $45 Copay.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $45 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 - $45 Copay. Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 40% Coinsurance. Routine hearing exam (up to 1 visit(s) every year): 40% Coinsurance.	**In-Network:** Exam to diagnose and treat hearing and balance issues: $40 Copay. Routine hearing exam (up to 1 visit(s) every year): $0 - $40 Copay. Hearing Aid (up to 2 hearing aids every year): $599 - $899 Copay. **Out-of-Network:** Exam to diagnose and treat hearing and balance issues: 30% Coinsurance. Routine hearing exam (up to 1 visit(s) every year): 30% Coinsurance.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Dental Services	**In-Network:** Medicare Covered: $40 Copay. **Out-of-Network:** Medicare Covered: 30% Coinsurance. **In and Out-of-Network:** You receive $1,000 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider in the United States.	**In-Network:** Medicare Covered: $45 Copay. **Out-of-Network:** Medicare Covered: 40% Coinsurance. **In and Out-of-Network:** You receive $725 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider in the United States.	**In-Network:** Medicare Covered: $40 Copay. **Out-of-Network:** Medicare Covered: 30% Coinsurance. **In and Out-of-Network:** You receive $1,400 allowance on a prepaid Benefits Mastercard toward diagnostic, preventive and restorative dental services per year. This benefit may be used at any dental provider in the United States.
Vision Services	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $40 Copay. Routine eye exam (up to 1 visit(s) every year): $20 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay **Out-of-Network:** Exam to diagnose and treat diseases and	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $45 Copay. Routine eye exam (up to 1 visit(s) every year): $20 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay **Out-of-Network:** Exam to diagnose and treat diseases and	**In-Network:** Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $40 Copay. Routine eye exam (up to 1 visit(s) every year): $20 Copay. Eyeglasses or contact lenses after cataract surgery: $0 Copay **Out-of-Network:** Exam to diagnose and treat diseases and

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
	conditions of the eye (including yearly glaucoma screening): 30% Coinsurance. Routine eye exam (up to 1 visit(s) every year): 30% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 30% Coinsurance. **In and Out-of-Network:** You receive $175 allowance on a prepaid Benefits Mastercard every year for eyewear.	conditions of the eye (including yearly glaucoma screening): 40% Coinsurance. Routine eye exam (up to 1 visit(s) every year): 40% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 40% Coinsurance. **In and Out-of-Network:** You receive $125 allowance on a prepaid Benefits Mastercard every year for eyewear.	conditions of the eye (including yearly glaucoma screening): 30% Coinsurance. Routine eye exam (up to 1 visit(s) every year): 30% Coinsurance. Eyeglasses or contact lenses after cataract surgery: 30% Coinsurance. **In and Out-of-Network:** You receive $225 allowance every year on a prepaid Benefits Mastercard for eyewear.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Mental Health Care	**In-Network:** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: Days 1-5: $300 Copay per day for each admission. Days 6-90: $0 Copay per day. **Out-of-Network:** Outpatient group therapy visit: $60 Copay. Individual therapy visit: $60 Copay. Inpatient Mental Health Care: 30% Coinsurance per stay.	**In-Network:** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: Days 1-5: $455 Copay per day for each admission. Days 6-90: $0 Copay per day. **Out-of-Network:** Outpatient group therapy visit: 40% Coinsurance. Individual therapy visit: 40% Coinsurance. Inpatient Mental Health Care:40% Coinsurance per stay.	**In-Network:** Outpatient group therapy visit: $40 Copay. Individual therapy visit: $40 Copay. Inpatient Mental Health Care: Days 1-6: $310 Copay per day for each admission. Days 7-90: $0 Copay per day. **Out-of-Network:** Outpatient group therapy visit: $60 Copay. Individual therapy visit: $60 Copay. Inpatient Mental Health Care:30% Coinsurance per stay
Skilled Nursing Facility (SNF)	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $145 Copay per day. **Out-of-Network:** 30% Coinsurance per stay. May require prior authorization.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $184 Copay per day. **Out-of-Network:** 40% Coinsurance per stay. May require prior authorization.	**In-Network:** Days 1-20: $0 Copay per day. Days 21-100: $145 Copay per day. **Out-of-Network:** 30% Coinsurance per stay. May require prior authorization.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Outpatient Rehabilitation	**In-Network:** Occupational therapy visit: $40 Copay. Physical therapy and speech and language therapy visit: $40 Copay. **Out-of-Network:** Occupational therapy visit: $60 Copay. Physical therapy and speech and language therapy visit: $60 Copay.	**In-Network:** Occupational therapy visit: $40 Copay. Physical therapy and speech and language therapy visit: $40 Copay. **Out-of-Network:** Occupational therapy visit: 40% Coinsurance. Physical therapy and speech and language therapy visit: 40% Coinsurance.	**In-Network:** Occupational therapy visit: $40 Copay. Physical therapy and speech and language therapy visit: $40 Copay. **Out-of-Network:** Occupational therapy visit: $60 Copay. Physical therapy and speech and language therapy visit: $60 Copay.
Ambulance	**In-Network:** Ground Ambulance: $255 Copay. Air Ambulance: $255 Copay. **Out-of-Network:** Ground Ambulance: $255 Copay. Air Ambulance: $255 Copay.	**In-Network:** Ground Ambulance: $265 Copay. Air Ambulance: $265 Copay. **Out-of-Network:** Ground Ambulance: $265 Copay. Air Ambulance: $265 Copay.	**In-Network:** Ground Ambulance: $255 Copay. Air Ambulance: $255 Copay. **Out-of-Network:** Ground Ambulance: $255 Copay. Air Ambulance: $255 Copay.
Transportation	**In-Network:** $0 Copay. No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.	**In-Network:** $0 Copay. No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.	**In-Network:** $0 Copay. No limit to non-emergent and/or routine transportation requests when deemed medically necessary and/or appropriate by CDPHP Case Management staff.

Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
	Out-of-Network: Not Covered.	**Out-of-Network:** Not Covered.	**Out-of-Network:** Not Covered.
Medicare Part B Drugs	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 0% - 20% Coinsurance. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 30% Coinsurance. Other Part B drugs: 30% Coinsurance. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 0% - 20% Coinsurance. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 40% Coinsurance. Other Part B drugs: 40% Coinsurance. May require prior authorization.	**In-Network:** For Part B drugs such as chemotherapy drugs: 20% Coinsurance. Other Part B drugs: 0% - 20% Coinsurance. **Out-of-Network:** For Part B drugs such as chemotherapy drugs: 30% Coinsurance. Other Part B drugs: 30% Coinsurance. May require prior authorization.

PRESCRIPTION DRUG BENEFITS			
Benefits/Services	**CDPHP Focus (PPO)**	**CDPHP Vital Rx (PPO)**	**CDPHP Complete Rx (PPO)**
Prescription Drug Deductible	N/A	$300 for Tiers 3, 4 and 5.	N/A

Initial Coverage

You pay the following until your total yearly drug costs reach $2,000. Total yearly drug costs are the drug costs paid by both you and our Part D plan.

	Preferred Retail Cost-Sharing	**Preferred Retail Cost-Sharing**	**Preferred Retail Cost-Sharing**
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	N/A	$0 Copay	$0 Copay
Tier 2 (Generic)	N/A	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	N/A	$47 Copay	$44 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	29% Coinsurance	33% Coinsurance

Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	N/A	$0 Copay	$0 Copay
Tier 2 (Generic)	N/A	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	N/A	$94 Copay	$88 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	N/A	$0 Copay	$0 Copay
Tier 2 (Generic)	N/A	$0 Copay	$0 Copay
Tier 3 (Preferred Brand)	N/A	$141 Copay	$132 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance

Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

	Standard Retail Cost-Sharing	Standard Retail Cost-Sharing	Standard Retail Cost-Sharing
Tier	**One-month supply**	**One-month supply**	**One-month supply**
Tier 1 (Preferred Generic)	N/A	$6 Copay	$5 Copay
Tier 2 (Generic)	N/A	$20 Copay	$19 Copay
Tier 3 (Preferred Brand)	N/A	$47 Copay	$47 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	29% Coinsurance	33% Coinsurance

Tier	**Two-month supply**	**Two-month supply**	**Two-month supply**
Tier 1 (Preferred Generic)	N/A	$12 Copay	$10 Copay
Tier 2 (Generic)	N/A	$40 Copay	$38 Copay
Tier 3 (Preferred Brand)	N/A	$94 Copay	$94 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	N/A	$18 Copay	$15 Copay
Tier 2 (Generic)	N/A	$60 Copay	$57 Copay
Tier 3 (Preferred Brand)	N/A	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

	Preferred Mail Order	Preferred Mail Order	Preferred Mail Order
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	N/A	$0 Copay	$0 Copay
Tier 2 (Generic)	N/A	$0 Copay	$0 Copay

Tier 3 (Preferred Brand)	N/A	$94 Copay	$88 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

	Standard Mail Order	**Standard Mail Order**	**Standard Mail Order**
Tier	**Three-month supply**	**Three-month supply**	**Three-month supply**
Tier 1 (Preferred Generic)	N/A	$18 Copay	$15 Copay
Tier 2 (Generic)	N/A	$60 Copay	$57 Copay
Tier 3 (Preferred Brand)	N/A	$141 Copay	$141 Copay
Tier 4 (Non-Preferred Drug)	N/A	40% Coinsurance	45% Coinsurance
Tier 5 (Specialty Tier)	N/A	Not Applicable	Not Applicable

Your cost-sharing may be different if you use a Long-Term Care pharmacy.

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

Please call us or see the plan's **"Evidence of Coverage"** on our website (www.https://www.cdphp.com/medicare) for complete information about your costs for covered drugs.

Catastrophic Amount

After your yearly out-of-pocket drug costs reach $2,000, your prescription drugs are covered in full.

Additional Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
Chiropractic Office Visits	**In-Network:** $15 Copay per visit **Out-of-Network:** 30% Coinsurance	**In-Network:** $15 Copay per visit **Out-of-Network:** 40% Coinsurance	**In-Network:** $15 Copay per visit **Out-of-Network:** 30% Coinsurance
Fitness Benefit	**In-Network:** $0 Copay per month **Out-of-Network:** Not covered.	**In-Network:** $0 Copay per month **Out-of-Network:** Not Covered.	**In-Network:** $0 Copay per month **Out-of-Network:** Not covered.
Foot Care podiatry services	**In-Network:** $40 Copay per visit **Out-of-Network:** $60 Copay per visit	**In-Network:** $45 Copay per visit **Out-of-Network:** 40% Coinsurance	**In-Network:** $40 Copay per visit **Out-of-Network:** $60 Copay per visit
Medical Equipment/Supplies	**In-Network:** Durable medical equipment and prosthetics: 20% Coinsurance Diabetes monitoring supplies: Lesser of $10 or 20% Coinsurance **Out-of-Network:** Durable medical equipment and prosthetics: 30% Coinsurance Diabetes monitoring supplies: 30% Coinsurance	**In-Network:** Durable medical equipment and prosthetics: 25% Coinsurance Diabetes monitoring supplies: 20% Coinsurance. **Out-of-Network:** Durable medical equipment and prosthetics: 50% Coinsurance Diabetes monitoring supplies: 40% Coinsurance	**In-Network:** Durable medical equipment and prosthetics: Lesser of 25% Coinsurance up to $300 maximum per item. Diabetes monitoring supplies: $10 or 20% Coinsurance. **Out-of-Network:** Durable medical equipment and prosthetics: 30% Coinsurance Diabetes monitoring supplies: 30% Coinsurance
Virtual Doctor's Visits Telemedicine	**In-Network:** $0*-$40 Copay per visit. See an urgent care or behavioral health provider using your computer or mobile	**In-Network:** $0*-$45 Copay per visit. See an urgent care or behavioral health provider using your computer or mobile	**In-Network:** $0*-$40 Copay per visit. See an urgent care or behavioral health provider using your computer or mobile

Additional Benefits/Services	CDPHP Focus (PPO)	CDPHP Vital Rx (PPO)	CDPHP Complete Rx (PPO)
	device. See EOC for more details. *Copay waived if using preferred telemedicine providers	device. See EOC for more details. *Copay waived if using preferred telemedicine providers	device. See EOC for more details. *Copay waived if using preferred telemedicine providers
Over the Counter (OTC Items)	$50 per quarter on a prepaid Benefits Mastercard to use on approved health products.	Not Covered	$50 per quarter on a prepaid Benefits Mastercard to use on approved health products.
In-home Support Services	30 hours per year of in-home support services.	60 hours per year of in-home support services.	60 hours per year of in-home support services.
Post Discharge Meal Benefit	$0 Copay Benefit is for 7 days 14 meals per inpatient or SNF discharge.	$0 Copay Benefit is for 7 days 14 meals per inpatient or SNF discharge.	$0 Copay Benefit is for 7 days 14 meals per inpatient or SNF discharge.

DISCLAIMERS

This document is available in other alternate formats.

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

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

CDPHP Focus (PPO), **CDPHP Vital Rx (PPO)** and **CDPHP Complete Rx (PPO)** is a Local PPO plan with a Medicare contract. Enrollment in **CDPHP Focus (PPO)**, **CDPHP Vital Rx (PPO)** and **CDPHP Complete Rx (PPO)** depends on contract renewal.

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

You must continue to pay your Medicare Part B premium.

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

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

Health coverage is offered by CDPHP Universal Benefits, Inc.

Pre-Enrollment Checklist

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

Understanding the Benefits

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

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/co-insurance may change on January 1, 2026.
- ☐ Our plan allows you to see providers outside of our network (non-contracted providers). However, while we will pay for covered services, the provider must agree to treat you. Except in an emergency or urgent situation, non-contracted providers may deny care. In addition, you will pay a higher co-pay for services received by non-contracted providers.
- ☐ Effect on Current Coverage. Your current health care coverage will end once your new Medicare coverage starts. For example, if you are in Tricare or a Medicare plan, you will no longer receive benefits from that plan once your new coverage starts.

THANK YOU

Connect with us

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

Organization Name: CDPHP Universal Benefits,® Inc.

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