2017 CDPHP® Medicare Choices Group PPO Benefit Summary

Service Category	Service	In-Network Cost-Share**	Out-of-Network Cost-Share
Annual Out-of-Pocket Limit	Member Responsibility	$3,350 Combined In And Out-of-Network Per Year	
Physician and Other Health Professional Services	Primary Care Physician Visits	$10	$20
	Specialty Visits	$15	$30
	Urgent Care	$25*	$25*
	Emergency Room Care (Worldwide)	$75	$75
	Ambulance	$100	$100
Hospital, Skilled Services, and Renal Care	Inpatient Hospital	No Copay	$500
	Outpatient Hospital	$125	$250
	Skilled Nursing Facility Services (Limited To 100 Days Per Benefit Period)	No Copay	
	Dialysis (In And Out Of Network)	$15	$15
Diagnostic Testing Services	Laboratory Services	$15 (Waived If Preferred)	$30
	Radiology And Imaging (X-Rays, Ultrasounds)	$15	$30
	Advanced Imaging (CT Scan, MRI, PET Scan)	$30	$60
Rehabilitation Services	Physical, Speech, And Occupational Therapy	$15	$30
	Chiropractic Benefits	$15	$30
Supplies and Devices	Diabetic Supplies	20% Co-insurance Or $10 Copay, Whichever Is Less	
	Prosthetic Devices, Durable Medical Equipment, And Diabetic DME	20% Co-insurance	
Mental Health and Chemical Dependency Services	Inpatient	No Copay	$500
	Outpatient	$15	$30
	Partial Hospitalization	No Copay	$55
Part B Prescription Drug	Administered In Any Outpatient Setting (Per Date Of Service)	$20	$40
	Retail Pharmacy (Per Prescription)	$20	$40
Hearing	Hearing Exam (Limited To One Per Year)	$15	$30
	Hearing Aids	$200 Allowance Per Year	
Vision	Vision Exam (Limited To One Per Year)	$15	$30
	Vision Eyewear	$100 Allowance Per Year	
Wellness	Senior Fit Program® Includes: Ciccotti Center, Beltrone Living Center, Silver Sneakers®	No Copay	

*New/Updated for 2017 **Cost-share per date of service unless otherwise indicated

CDPHP Universal Benefits,® Inc. (CDPHP UBI) is a PPO with a Medicare contract. Enrollment in CDPHP Medicare Choices depends on contract renewal.

Out-of-network/non-contracted providers are under no obligation to treat CDPHP 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 customer service number or see your *Evidence of Coverage* for more information, including the cost-sharing that applies to out-of-network services.

If you have a question or wish to receive additional information, please contact the member services department at (518) 641-3950 or 1-888-248-6522 (TTY/TDD 711). Or, visit our website at www.cdphp.com. This summary is designed to highlight the benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. Many preventive services are covered in full. For more detailed information, an *Evidence of Coverage* is available for your review upon request.

RIDER FOR GROUP MEDICARE ENHANCED PHARMACY COVERAGE

The *Evidence of Coverage* to which this rider is attached is amended as follows:

CHAPTER 6: WHAT YOU PAY FOR YOUR PART D PRESCRIPTION DRUGS

Drug Tier	Retail In-Network Copay (30-day supply)	Retail In-Network Copay (90-day supply)	Long-Term Care In-Network Copay (31-day supply)	Caremark Mail-Order Copay (30-day supply)	Caremark Mail-Order Copay (90-day supply)	Out-of-Network Copay* (30-day supply)
Tier 1 Preferred Generic	$0	$0	$0	$0	$0	$0
Tier 2 Generic	$5	$15	$5	$5	$10	$5
Tier 3 Preferred Brand	$20	$60	$20	$20	$40	$20
Tier 4 Non-Preferred Drug	$35	$105	$35	$35	$70	$35
Tier 5 Specialty Tier	$35	N/A	$35	$35	N/A	$35

You are subject to a $0 deductible per benefit period.

During the Initial Coverage Stage, your copayments or coinsurance for covered Part D drugs under the CDPHP® Medicare Choices Drug Plans Formulary are as shown above in the cost-share grid. Once you have reached your Initial Coverage Limit totaling $3,700, a Coverage Gap begins. In the Coverage Gap under this rider, your copayments or coinsurance for covered Part D drugs under the CDPHP® Medicare Choices Drug Plans Formulary are as shown above in the cost-share grid.

You pay this reduced cost-sharing until your total out-of-pocket Part D drug costs reach $4,950 and you qualify for Catastrophic Coverage. Catastrophic Coverage applies only to covered Part D drugs. During Catastrophic Coverage you pay the greater of 5% coinsurance or $3.30 for generic and multisource brand drugs, and the greater of 5% coinsurance or $8.25 for all other drugs in Tiers 1 through 4. For Tier 5 drugs, you pay the lesser of 5% coinsurance or the above stated cost share.

In addition to the Part D drugs covered under the Group Medicare Rx Plan, CDPHP® has added expanded coverage, with additional categories of prescription drugs covered under the CDPHP Medicare Choices Drug Plans Enhanced Formulary. Please review the enclosed copy of the Enhanced Formulary to see a list of covered drugs. Amounts you pay out of pocket for non-Part D drugs, including Enhanced Formulary drugs, do not count toward the calculation of total drug costs nor do they count toward your out-of-pocket maximum of $4,950. For non-Part D drugs covered under the Enhanced Formulary, you will continue to pay the copayments noted above even after you have reached the Catastrophic Coverage level for Part D drugs. Enhanced Formulary drugs covered under this plan are not considered covered Part D drugs by Medicare; therefore, the following items do not apply to Enhanced Formulary drugs:

- 60-day advance notice of formulary changes.
- One-time fills for non-covered drugs for new members.
- Formulary exceptions for coverage levels (tier placement).
- Explanation of Benefits.

This summary does not detail all benefits, limitations, or exclusions. The terms of the Evidence of Coverage to which this rider is attached shall remain in full force and effect, except as amended by this rider. CDPHP® is an HMO and PPO with a Medicare contract. Enrollment in CDPHP Medicare Choices depends on contract renewal.

2017 CDPHP® Medicare Choices
RIDER FOR GROUP MEDICARE DENTAL COVERAGE

The *Evidence of Coverage* to which this rider is attached is amended as follows:

You are entitled to reimbursement for the following services up to a total of $250 per benefit year from the provider of your choice:

A. Comprehensive oral exams, limited to two per benefit year.

B. Prophylaxis (cleanings), limited to two per benefit year.

C. Fluoride applications, limited to once per benefit year.

D. X-rays (full mouth, panoramic, bitewing, and intraoral), limited to once per benefit year.

Submit your receipt and proof of payment to CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206.

The terms of the Evidence of Coverage to which this Rider is attached shall remain in full force and effect, except as amended by this Rider.

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