

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-777-2273 . For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at [www.cdphp.com/contracts](http://www.cdphp.com/contracts) or call 1-800-777-2273 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<b>In Network:</b> \$250/Individual, \$500/Family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	<a href="#">Deductible</a> does not apply to <a href="#">Preventive care/screening</a> /immunization	This <a href="#">plan</a> covers some items and services even if you haven't yet met the annual <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<b>In Network:</b> \$600/Individual, \$1,200/Family	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limit</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.cdphp.com/contracts">www.cdphp.com/contracts</a> or call 1-800-777-2273 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a referral.

\*If applicable, you may be able to use your Flexible Spending Account and/or your Health Reimbursement Arrangement to cover these costs. Refer to the Summary Plan Description and Plan Document for more information.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary Care visit to treat an injury or illness.	\$25 <a href="#">copayment</a> /visit	Not Covered	You may use live video visits at <a href="http://www.doctorondemand.com">www.doctorondemand.com</a> .
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> /visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	None
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 <a href="#">copayment</a> /visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copayment</a> /visit	Not Covered	None
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.cdphp.com/Members/Rx-Corner">https://www.cdphp.com/Members/Rx-Corner</a>	Tier 1 drugs	Retail: \$10 <a href="#">copayment</a> Mail order: \$20 <a href="#">copayment</a>	Retail: Not Covered Mail order: Not Covered	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription) Prescriptions must be written by a duly licensed health care provider and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP. Specialty drugs are not eligible for the mail order program. This plan has Formulary 2.
	Tier 2 drugs	Retail: \$50 <a href="#">copayment</a> Mail order: \$100 <a href="#">copayment</a>	Retail: Not Covered Mail order: Not Covered	
	Tier 3 drugs	Retail: \$80 <a href="#">copayment</a> Mail order: \$160 <a href="#">copayment</a>	Retail: Not Covered Mail order: Not Covered	
	<a href="#">Specialty drugs</a>	Retail: \$10 <a href="#">copayment</a> / \$50 <a href="#">copayment</a> / \$80 <a href="#">copayment</a>	Not Covered	Drugs obtained at non-preferred retail pharmacies are subject to 50% <a href="#">coinsurance</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$150 <a href="#">copayment</a> /visit	Not Covered	None
	Physician/surgeon fees	\$100 <a href="#">copayment</a> /visit	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <a href="#">copayment</a> /visit	\$250 <a href="#">copayment</a> /visit	All Emergency Care is considered In-Network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copayment</a> /visit	\$250 <a href="#">copayment</a> /visit	All Emergency Care is considered In-Network.
	<a href="#">Urgent care</a>	\$75 <a href="#">copayment</a> /visit	\$75 <a href="#">copayment</a> /visit	Urgent Care from Non-Participating Urgent Care Centers in Our Service Area are not covered. You may use <a href="#">live video visits</a> .
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,000 <a href="#">copayment</a> /stay	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copayment</a> /visit	Not Covered	20 visits for family counseling.
	Inpatient services	\$1,000 <a href="#">copayment</a> /stay	Not Covered	None
<b>If you are pregnant</b>	Office visits	No Charge	Not Covered	Cost share applies for Initial visit to determine pregnancy, subsequent visits are Covered in Full.
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	\$1,000 <a href="#">copayment</a> /stay	Not Covered	None
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	Not Covered	Limited to 40 visits per year
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copayment</a> /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copayment</a> /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.
	<a href="#">Skilled nursing care</a>	\$1,000 <a href="#">copayment</a> /stay	Not Covered	365 days per year
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	Not Covered	Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
	<a href="#">Hospice services</a>	\$25 <a href="#">copayment</a> /visit	Not Covered	Limited to 210 days per year
<b>If your child needs dental or eye care</b>	Children's eye exam	\$25 <a href="#">copayment</a> /visit	Not Covered	One child routine eye exam per benefit period
	Children's glasses	50% <a href="#">coinsurance</a>	Not Covered	Coverage is limited to "Standard" eyeglasses for children.
	Children's dental check-up	Not Covered	Not Covered	Preventive Dental is not covered under your medical benefits.

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture 10 visits per year
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is as follows: Contact CDPHP at 1-800-777-2273 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or <http://www.dfs.ny.gov/>, the Health Insurance Assistance Team of the U.S. Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov/), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit <https://nystateofhealth.ny.gov/> or call 1.855.355.5777 (TTY: 1.800.662.1220).

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a claim. This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your plan documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: CDPHP at 1-800-777-2273 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or <http://www.dfs.ny.gov/>, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

### Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the Minimum Value Standards? **Not Applicable**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

**Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$1,000
- Other [copayment](#) \$50

This EXAMPLE event includes services like:

- Specialist office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (*ultrasounds and blood work*)
- Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$550</b>

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$25
- Hospital (facility) [copayment](#) \$1,000
- Other [copayment](#) \$50

This EXAMPLE event includes services like:

- Primary care physician office visits (*including disease education*)
- Diagnostic tests (*blood work*)
- Prescription drugs
- Durable medical equipment (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$350</b>

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$250
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$1,000
- Other [copayment](#) \$25

This EXAMPLE event includes services like:

- Emergency room care (*including medical supplies*)
- Diagnostic test (*x-ray*)
- Durable medical equipment (*crutches*)
- Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$200
<b>The total Mia would pay is</b>	<b>\$800</b>



Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

