Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period: Beginning on or after 01/01/2025

Essential Plan 200-250 **Coverage for:** Individual | **Plan Type:** HMO

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 or call 1-800-777-2273 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cdphp.com or call 1-800-777-2273 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 **co-pay** /visit	Not Covered	You may use live video visits at www.doctorondemand.com.
	Specialist visit	$25 **co-pay** /visit	Not Covered	None.
	Preventive care/screening/ immunization	No Charge	Not Covered	None.
If you have a test	**Diagnostic test** (x-ray, blood work)	$25 **co-pay** /visit	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	$25 **co-pay** /visit	Not Covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **http://www.cdphp.com/Members/Rx-Corner**	Tier 1 drugs	Retail $6 **co-pay** Mail-Order: $15 **co-pay**	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 and require preauthorization to be obtained through CDPHP's participating specialty vendors. This plan has Formulary 2.
	Tier 2 drugs	Retail: $15 **co-pay** Mail-Order:$37.50 **co-pay**	Not Covered	
	Tier 3 drugs	Retail: $30 **co-pay** Mail-Order: $75 **co-pay**	Not Covered	
	Specialty drugs	Retail: $30 **co-pay**	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 **co-pay** /visit	Not Covered	None.
	Physician/surgeon fees	$50 **co-pay** /visit	Not Covered	None.
If you need immediate medical attention	Emergency room care	$75 **co-pay** /visit	$75 **co-pay** /visit	All Emergency Care is considered In-Network.
	Emergency medical transportation	$75 **co-pay** /visit	$75 **co-pay** /visit	All Emergency Care is considered In-Network.
	Urgent care	$25 **co-pay** /visit	$25 **co-pay** /visit	Urgent Care from Non-Participating Urgent Care Centers in Our Service Area are not covered. You may use **live video visits**.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 **co-pay** /admission	Not Covered	None.
	Physician/surgeon fees	$50 **co-pay** /surgery	Not Covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 **co-pay** /visit	Not Covered	None.
	Inpatient services	$150 **co-pay** /visit	Not Covered	None.
If you are pregnant	Office visits	$0 **co-pay** /visit	Not Covered	None.
	Childbirth/delivery professional services	$0 **co-pay**	Not Covered	None.
	Childbirth/delivery facility services	$0 **co-pay**/admission	Not Covered	None.
If you need help recovering or have other special health needs	Home health care	$15 **co-pay** /visit	Not Covered	Up to 40 home health care visits are covered per plan year.
	Rehabilitation services	$15 **co-pay** /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.
	Habilitation services	$15 **co-pay** /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Skilled nursing care	$150 **co-pay** /visit	Not Covered	Up to 200 days are covered per plan year.
	Durable medical equipment	5% **co-insurance**	Not Covered	Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered.
	Hospice services	$15 **co-pay** /visit	Not Covered	Limited to 210 days per plan year.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Children are not covered on this plan.
	Children's glasses	Not Covered	Not Covered	Children are not covered on this plan.
	Children's dental check-up	Not Covered	Not Covered	Children are not covered on this plan.

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.)

- Acupuncture
- Cosmetic surgery
- 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.)

- Bariatric surgery (Limits Apply)
- Chiropractic care
- Dental care (Adult)
- Dental checkup
- Eye exam
- Routine eye care (Adult)
- Glasses
- Hearing aids
- Prescription Drug Coverage
- 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**, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html**.

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**.

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**

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	N/A
Specialist cost sharing	$25
Hospital (facility) cost sharing	$150
Other cost sharing	5%

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*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$0**

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

The plan's overall deductible	N/A
Specialist cost sharing	$25
Hospital (facility) cost sharing	$150
Other cost sharing	5%

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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$860**

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

The plan's overall deductible	N/A
Specialist cost sharing	$25
Hospital (facility) cost sharing	$150
Other cost sharing	5%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$10
What isn't covered	
Limits or exclusions	$40
The total Mia would pay is	**$450**

Estimate how much doctors and dentists in your area charge for services
www.fairhealthconsumer.org
FAIRHEALTH

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.