CDPHP® HMO Plan Benefit Summary

Plan Code: SHGFHNY1

Presented For: Healthy New York Benefit Summary

Effective Date: 1/1/2014

Metal Tier: GOLD

	In-Network
Deductible	$600 Single / $1,200 Family (Embedded)
Coinsurance	Not Applicable
Office Visits	
PCP	Deductible then $25 Copayment
Specialist	Deductible then $40 Copayment
Out of Pocket Maximum	$4,000 Single / $8,000 Family
Physician Services	
PCP Office Visits for illness, injury or second opinion	Deductible then $25 Copayment
Specialist Office Visits for illness, injury or second opinion	Deductible then $40 Copayment
Physician Visits during inpatient stay when billed separately from the facility	Covered in Full
Well Baby and Child Care including immunizations and inoculations	Covered in Full
Annual Adult Exam	Covered in Full
Annual Gynecological Exam	Covered in Full
Prescription Drug Coverage	
Tier 1 Drugs	$10 Copayment
Tier 1 Mail Order Drugs	$25 Copayment
Tier 2 Drugs	$35 Copayment
Tier 2 Mail Order Drugs	$88 Copayment
Tier 3 Drugs	$70 Copayment
Tier 3 Mail Order Drugs	$175 Copayment
Specialty Drugs	$70 Copayment
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 uses the Premier network and Formulary 2.	
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	Deductible then $1,000 Copayment
Outpatient Surgery	Deductible then $100 Copayment
Diagnostic Testing*	
Outpatient Hospital Laboratory Services:	Deductible then $40 Copayment
Outpatient Hospital Radiology Services:	Deductible then $40 Copayment
Office Based Laboratory Services:	Deductible then $40 Copayment
Office Based Radiology Services:	Deductible then $40 Copayment
Mammogram	Covered in Full
Cytology Screening	Covered in Full
Prostate Cancer Screening	Covered in Full
Maternity	
Physician Services when billed separately from the facility	Covered in Full
Inpatient Hospital Services	Deductible then $1,000 Copayment
Newborn Nursery	Deductible then Covered in Full
Emergency Care	
Worldwide Emergency Room Care	Deductible then $150 Copayment
Ambulance	Deductible then $150 Copayment

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Presented For: Healthy New York Benefit Summary

Group ID: PROSPECT

Effective Date: 1/1/2014

Metal Tier: GOLD

	In-Network
Urgent Care	
Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered	Deductible then $60 Copayment
Physical Therapy	
	Deductible then $30 Copayment (60 visits combined therapies (PT/OT/ST), per condition, per lifetime.)
Speech Therapy	
	Deductible then $30 Copayment (60 visits combined therapies (PT/OT/ST), per condition, per lifetime.)
Occupational Therapy	
	Deductible then $30 Copayment (60 visits combined therapies (PT/OT/ST), per condition, per lifetime.)
Chiropractic Benefits	Deductible then $40 Copayment
Home Health Care (40 visits per benefit period)	Deductible then $25 Copayment
Skilled Nursing Facility	Deductible then $1,000 Copayment (200 days per plan year)
Prosthetic Appliances and Durable Medical Equipment	Deductible then 20% Coinsurance (1 prosthetic/condition/lifetime)
Diabetic Services	
Insulin and oral Medication - up to a 30 day supply	Deductible then $25 Copayment
Diabetic Supplies (needles and syringes) - up to a 30 day supply	Deductible then $25 Copayment
Glucometers	Deductible then $25 Copayment
Diabetic DME	Deductible then $25 Copayment
Mental Health Services	
Outpatient services	Deductible then $25 Copayment
Inpatient services	Deductible then $1,000 Copayment
Chemical Abuse and Dependency Services	
Outpatient services	Deductible then $25 Copayment (Up to 20 visits a plan year may be used for Family Counseling without the patient.)
Inpatient services	Deductible then $1,000 Copayment
Inpatient Rehabilitation Services	Deductible then $1,000 Copayment
Vision Services	
Adult Vision Exam	Not Covered
Adult Glasses/Contacts	Not Covered
Pediatric Vision Exam	Deductible then $25 Copayment (One exam per 12 month period.)
Pediatric Glasses/Contacts	Deductible then 20% Coinsurance (One prescribed lenses and frames in a 12 month period. Standard Frames.)
Wellness Care	
Fitness Reimbursement	(Up to $200 per 6 month period; Up to an additional $100 per 6 month period for spouse.)
Dependent Coverage	Covered to Age 26

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This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.

CDPHP gives you access to more than 12,000 participating practitioners and providers, including most of the local hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

**Please visit our Web site at www.cdphp.com or contact CDPHP HMO member services at (518) 641-3700 or 1-800-777-2273 to identify designated laboratories and preferred radiology sites.*

All benefits of this plan are subject to coordination of benefits. This summary is designed to highlight 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. For more detailed information, a membership Certificate is available for your review upon request.

Please Note. All non-emergency services must be provided by a Capital District Physician's Health Plan, Inc. (CDPHP) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP.

A plan for life.