



HMO : HDHMO Non-Qualified 60, Bronze, ST3PCP, INN, Dep25

Coverage for: All Tiers

Plan Type: HDHMO



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> ?	In-Network: \$4,425 individual/\$8,850 family.	If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	<a href="#">Deductible</a> does not apply to <a href="#">preventive care</a> , and cost-share is waived for first three PCP visits.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <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 <a href="#">preventive services</a> 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> ?	In-Network: \$8,150 individual/ \$16,300 family.	If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</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 billed</a> charges, and health care this <a href="#">plan</a> doesn't 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">www.cdphp.com</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 <a href="#">provider's</a> 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> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

\*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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	50% <b>co-insurance</b>	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% <b>co-insurance</b>	Not Covered	Preauthorization required for Sleep Studies, Neurofeedback & Transcranial Magnetic Stimulation (TMS)
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	Preauthorization required for Genetic Testing and Immunizations for RSV.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	50% <b>co-insurance</b>	Not Covered	Preauthorization required for Genetic Testing.
	Imaging (CT/PET scans, MRIs)	50% <b>co-insurance</b>	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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="http://www.cdphp.com/Members/Rx-Corner">prescription drug coverage</a> is available at <a href="http://www.cdphp.com/Members/Rx-Corner">http://www.cdphp.com/Members/Rx-Corner</a></p>	Tier 1 drugs	Retail: \$10 <b>copay</b> Mail-Order: \$25 <b>copay</b>	Not Covered	<p>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. Preventive Prescription Drugs, as defined by the CDPHP formulary, are not subject to the plan Deductible. 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 and the Premier Rx Network.</p>
	Tier 2 drugs	Retail: \$35 <b>copay</b> Mail-Order: \$87.50 <b>copay</b>	Not Covered	
	Tier 3 drugs	Retail: \$70 <b>copay</b> Mail-Order: \$175 <b>copay</b>	Not Covered	
	<a href="#">Specialty drugs</a>	Retail: \$10 <b>copay</b> /\$35 <b>copay</b> /\$70 <b>copay</b>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% <b>co-insurance</b>	Not Covered	None.
	Physician/surgeon fees	50% <b>co-insurance</b>	Not Covered	None.
If you need immediate medical attention	<a href="#">Emergency room care</a>	50% <b>co-insurance</b>	50% <b>co-insurance</b>	All Emergency Care is considered In-Network.
	<a href="#">Emergency medical transportation</a>	50% <b>co-insurance</b>	50% <b>co-insurance</b>	All Emergency Care is considered In-Network.
	<a href="#">Urgent care</a>	50% <b>co-insurance</b>	50% <b>co-insurance</b>	Urgent Care from Non-Participating Urgent Care Centers in Our Service Area are not covered. You may use <a href="#">live video visits</a> .
If you have a hospital stay	Facility fee (e.g., hospital room)	50% <b>co-insurance</b>	Not Covered	None.
	Physician/surgeon fees	50% <b>co-insurance</b>	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	50% <b>co-insurance</b>	Not Covered	Preauth needed - Residential Treatment, 20 visits for family counseling.
	Inpatient services	50% <b>co-insurance</b>	Not Covered	Preauth required for Residential Treatment, with the exception of some scenarios.
If you are pregnant	Office visits	50% <b>co-insurance</b>	Not Covered	Abortions (exempt and non-exempt) are covered under your medical benefit, Limits apply. Cost share may apply for initial visit to determine pregnancy.
	Childbirth/delivery professional services	50% <b>co-insurance</b>	Not Covered	None.
	Childbirth/delivery facility services	50% <b>co-insurance</b>	Not Covered	Physician fee is in addition to the facility fee for the delivery.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	50% <b>co-insurance</b>	Not Covered	Limited to 40 days per plan year.
	<a href="#">Rehabilitation services</a>	50% <b>co-insurance</b>	Not Covered	60 consecutive inpatient days per plan year for PT/OT/ST services.
	<a href="#">Habilitation services</a>	50% <b>co-insurance</b>	Not Covered	60 consecutive inpatient days per plan year for PT/OT/ST services.

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)	
	<a href="#">Skilled nursing care</a>	50% <b>co-insurance</b>	Not Covered	Preauthorization required. Limited to 200 days per plan year.
	<a href="#">Durable medical equipment</a>	50% <b>co-insurance</b>	Not Covered	Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered. Durable medical equipment that is rented, repaired, replaced or costs more than \$1000 requires prior authorization before receiving care, otherwise penalty applies (see contract for details).
	<a href="#">Hospice services</a>	50% <b>co-insurance</b>	Not Covered	Limited to 210 days per plan year.
If your child needs dental or eye care	Children's eye exam	50% <b>co-insurance</b>	Not Covered	One child routine eye exam per benefit period
	Children's glasses	50% <b>co-insurance</b>	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](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental checkup
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Hearing aids
- Infertility treatment (21-44 years old)
- Weight loss programs (Limits Apply)

**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**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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.*-----

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](#) **\$4,425.00**
- [Specialist cost sharing](#) **50%**
- Hospital (facility) [cost sharing](#) **50%**
- Other [cost sharing](#) **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>\$12,731.28</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$7150.00
Copayments	\$0.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Peg would pay is</b>	<b>\$7150.00</b>

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

- The [plan's](#) overall [deductible](#) **\$4,425.00**
- [Specialist cost sharing](#) **50%**
- Hospital (facility) [cost sharing](#) **50%**
- Other [cost sharing](#) **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>\$7,389.29</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$3377.71
Copayments	\$164.27
Coinsurance	\$1850.55
<i>What isn't covered</i>	
Limits or exclusions	\$0.00
<b>The total Joe would pay is</b>	<b>\$5392.53</b>

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

- The [plan's](#) overall [deductible](#) **\$4,425.00**
- [Specialist cost sharing](#) **50%**
- Hospital (facility) [cost sharing](#) **50%**
- Other [cost sharing](#) **50%**

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>\$1,925.04</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1763.04
Copayments	\$0.00
Coinsurance	\$0.00
<i>What isn't covered</i>	
Limits or exclusions	\$162.00
<b>The total Mia would pay is</b>	<b>\$1925.04</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.





## **Discrimination is Against the Law**

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

### **CDPHP:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at <https://www.cdphp.com/customer-support/email-cdphp>. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

### **Multi-language Interpreter Services**

**ATTENTION:** If you speak a non-English language, language assistance services, free of charge, are available to you. Call the number on your member ID card (TTY: 711).

**ATENCIÓN:** Si habla otro idioma que no es el inglés, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que figura en su tarjeta de identificación de miembro (TTY: 711).

**注意：**如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員 ID 卡上的電話（聽力障礙電傳：711）。



ВНИМАНИЕ: Если вы говорите на иностранном языке, вы можете воспользоваться бесплатными услугами перевода. Позвоните по номеру на вашей ID карточке участника (Телетайп: 711).

ATANSYON: Si ou pale yon lang ki pa Angle, wap jwenn sèvis asistans lang gratis disponib pou ou. Rele nimewo ki sou kat ID manm ou a (TTY: 711).

주의: 영어 이외의 언어를 사용하는 경우 무료로 언어 지원 서비스를 받을 수 있습니다. 귀하의 회원 ID 카드에 있는 번호로 전화하십시오(TTY: 711).

ATTENZIONE: Se non parla inglese né una lingua anglofona, sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero presente sulla scheda ID dei membri (TTY: 711).

אויפגעקזאם: אויב איר רעדט , זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט דעם נומער אויף אייער מעמבער ID קארטל (711:TTY)

মনোযোগ দিন: আপনি যদি ইংরেজি বহির্ভূত কোন ভাষায় কথা বলেন ,আপনার জন্য বিনা খরচায় ভাষা সহায়তা উপলভ্য রয়েছে। আপনার সদস্য আইডি কার্ডের নম্বরে কল করুন (TTY: 711)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer na Twojej członkowskiej karcie ID (TTY: 711).

تنبيه: إذا كنت تتحدث لغة غير الإنجليزية، تتوفر إليك خدمات مساعدة اللغة مجاناً. اتصل بالرقم الموجود ببطاقة الهوية لعضويتك (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez au numéro indiqué sur votre carte de membre (ATS : 711).

توجه دیں: اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے ممبر آئی ڈی کارڈ پر درج نمبر پر کال کریں (TTY: 711)۔

ATENSYON: Kung nagsasalita kayo ng wikang iba sa Ingles, magagamit niyo ang mga serbisyo sa tulong sa wika nang walang bayad. Tawagan ang numero sa inyong card miyembro ID (TTY: 711).

ΠΡΟΣΟΧΗ: Αν δεν μιλάτε Αγγλικά, υπάρχουν στη διάθεσή σας υπηρεσίες γλωσσικής υποστήριξης οι οποίες παρέχονται δωρεάν. Καλέστε τον αριθμό που θα βρείτε στην ατομική σας ταυτότητα μέλους (TTY: 711).

VINI RE: Nëse flisni një gjuhë jo-anglisht, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Telefonojini numrit në kartën tuaj të ID të anëtarit (TTY: 711).