



HMO : HMO Copayment 30, Silver, CSR1, ST, INN, Dep25

Coverage for: All Tiers

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 ? | In-Network: \$1,925 individual/\$3,850 family. | If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . |
| Are there services covered before you meet your deductible ? | Deductible does not apply to preventive care and prescription drugs . | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| 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 ? | In-Network: \$7,550 individual/\$15,100 family. | If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| 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 ? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

*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 provider's office or clinic | Primary care visit to treat an injury or illness | \$30 co-pay /visit | Not Covered | You may use live video visits at www.doctorondemand.com . |
| | Specialist visit | \$65 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) | \$65 co-pay /visit | Not Covered | None. |
| | Imaging (CT/PET scans, MRIs) | \$175 co-pay /visit | Not Covered | None. |

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|---|--|--|--|--|
| | | 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: \$15 copay Mail-Order: \$37.50 copay Deductible does not apply | 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: \$40 copay Mail-Order: \$100 copay Deductible does not apply | Not Covered | |
| | Tier 3 drugs | Retail: \$75 copay Mail-Order: \$187.50 copay Deductible does not apply | Not Covered | |
| | Specialty drugs | Retail: \$15 copay /\$40 copay /\$75 copay Deductible does not apply | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$150 co-pay /visit | Not Covered | None. |
| | Physician/surgeon fees | \$150 co-pay /visit | No Charge | None. |
| If you need immediate medical attention | Emergency room care | \$275 co-pay /visit | \$275 co-pay /visit | All Emergency Care is considered In-Network. |
| | Emergency medical transportation | \$150 co-pay /visit | \$150 co-pay /visit | All Emergency Care is considered In-Network. |
| | Urgent care | \$70 co-pay /visit | \$70 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) | \$1,500 co-pay /visit | Not Covered | None. |
| | Physician/surgeon fees | \$150 co-pay /visit | Not Covered | None. |

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|---|---|--|--|--|
| | | 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 | \$30 co-pay /visit | Not Covered | 20 visits for family counseling. |
| | Inpatient services | \$1,500 co-pay /visit | Not Covered | None. |
| If you are pregnant | Office visits | \$65 co-pay /visit | 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 | \$150 co-pay /visit | Not Covered | None. |
| | Childbirth/delivery facility services | \$1,500 co-pay /visit | 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 | Home health care | \$30 co-pay /visit | Not Covered | Limited to 40 days per plan year. |
| | Rehabilitation services | \$1,500 co-pay /visit | Not Covered | None. |
| | Habilitation services | \$30 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 | \$1,500 co-pay /visit | Not Covered | None. |
| | Durable medical equipment | 25% co-insurance | Not Covered | Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered. |
| | Hospice services | \$1,500 co-pay /visit | Not Covered | Limited to 210 days per plan year. |
| If your child needs dental or eye care | Children's eye exam | \$30 co-pay /visit | Not Covered | One child routine eye exam per benefit period |
| | Children's glasses | 25% co-insurance | No Charge | 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
- 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, 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.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE and certain other coverage. If you are eligible for 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.-----

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 | \$1,925.00 |
| ■ Specialist cost sharing | \$65.00 |
| ■ Hospital (facility) cost sharing | \$1,500.00 |
| ■ Other cost sharing | N/A |

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 | \$12,686.85 |
|---------------------------|--------------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|------------------|
| Deductibles | \$1925.00 |
| Copayments | \$1571.49 |
| Coinsurance | \$0.00 |
| What isn't covered | |
| Limits or exclusions | \$0.00 |
| The total Peg would pay is | \$3496.49 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|------------|
| ■ The plan's overall deductible | \$1,925.00 |
| ■ Specialist cost sharing | \$65.00 |
| ■ Hospital (facility) cost sharing | \$1,500.00 |
| ■ Other cost sharing | N/A |

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 | \$5,601.10 |
|---------------------------|-------------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|------------------|
| Deductibles | \$1661.60 |
| Copayments | \$901.63 |
| Coinsurance | \$0.00 |
| What isn't covered | |
| Limits or exclusions | \$0.00 |
| The total Joe would pay is | \$2563.23 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|------------|
| ■ The plan's overall deductible | \$1,925.00 |
| ■ Specialist cost sharing | \$65.00 |
| ■ Hospital (facility) cost sharing | \$1,500.00 |
| ■ Other cost sharing | N/A |

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 | \$2,800.17 |
|---------------------------|-------------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|------------------|
| Deductibles | \$1925.00 |
| Copayments | \$65.24 |
| Coinsurance | \$0.00 |
| What isn't covered | |
| Limits or exclusions | \$211.56 |
| The total Mia would pay is | \$2201.80 |

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.

CDPHP Price Check

Take control of your health care dollars by estimating the cost of certain services before scheduling at
<https://member.cdphp.com/login>





Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc., CDPHP Universal Benefits, Inc., and Capital District Physicians' Healthcare Network, Inc. (collectively referred to as CDPHP®) comply with applicable federal civil rights laws and do 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).

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

মনোযোগ দিনঃ 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 مجانًا. 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).