CDPHP

HMO : HMO Copayment 14, Platinum, NS, INN, Dep25, Adult Vision, Lasik, Wellness 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?	$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?	In-Network: $3,000 individual/ $6,000 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.

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	No Charge	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: $5 **copay** Mail-Order: $10 **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. Drugs obtained at non-preferred retail pharmacies are subject to 50% coinsurance.
	Tier 2 drugs	Retail: $15 **copay** Mail-Order: $30 **copay** Deductible does not apply	Not Covered	
	Tier 3 drugs	Retail: $45 **copay** Mail-Order: $90 **copay** Deductible does not apply	Not Covered	
	Specialty drugs	Retail: $5 **copay**/$15 **copay**/$45 **copay** Deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 **co-pay**/visit	Not Covered	None.
	Physician/surgeon fees	$100 **co-pay**/visit	No Charge	None.
If you need immediate medical attention	Emergency room care	$200 **co-pay**/visit	$200 **co-pay**/visit	All Emergency Care is considered In-Network.
	Emergency medical transportation	$200 **co-pay**/visit	$200 **co-pay**/visit	All Emergency Care is considered In-Network.
	Urgent care	$50 **co-pay**/visit	$50 **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)	$250 **co-pay**/visit	Not Covered	None.
	Physician/surgeon fees	No Charge	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	No Charge	Not Covered	20 visits for family counseling.
	Inpatient services	$250 **co-pay**/visit	Not Covered	None.
If you are pregnant	Office visits	No Charge	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	No Charge	Not Covered	None.
	Childbirth/delivery facility services	$250 **co-pay**/visit	Not Covered	None.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 40 days per plan year.
	Rehabilitation services	$250 **co-pay**/visit	Not Covered	None.
	Habilitation services	$25 **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	$250 **co-pay**/visit	Not Covered	None.
	Durable medical equipment	50% **co-insurance**	Not Covered	Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered.
	Hospice services	$250 **co-pay**/visit	Not Covered	Limited to 210 days per plan year.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One child routine eye exam per benefit period
	Children's glasses	50% **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.)

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

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

- Acupuncture (Limits Apply)   • Hearing aids
- Bariatric surgery (Limits Apply)   • Infertility treatment   • Weight loss programs (Limits Apply)
- Chiropractic care   • Routine eye care (Adult)

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)	**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)	**Mia's Simple Fracture** (in-network emergency room visit and follow up care)

■ The plan's overall deductible **$0.00**	■ The plan's overall deductible **$0.00**	■ The plan's overall deductible **$0.00**
■ Specialist cost sharing **$25.00**	■ Specialist cost sharing **$25.00**	■ Specialist cost sharing **$25.00**
■ Hospital (facility) cost sharing **$250.00**	■ Hospital (facility) cost sharing **$250.00**	■ Hospital (facility) cost sharing **$250.00**
■ Other cost sharing **N/A**	■ Other cost sharing **N/A**	■ Other cost sharing **N/A**

This EXAMPLE event includes services like:

Peg	Joe	Mia
Specialist office visits (*prenatal care*)	Primary care physician office visits (*including disease education*)	Emergency room care (*including medical supplies*)
Childbirth/Delivery Professional Services	Diagnostic tests (*blood work*)	Diagnostic test (*x-ray*)
Childbirth/Delivery Facility Services	Prescription drugs	Durable medical equipment (*crutches*)
Diagnostic tests (*ultrasounds and blood work*)	Durable medical equipment (*glucose meter*)	Rehabilitation services (*physical therapy*)
Specialist visit (*anesthesia*)		

Total Example Cost	**$12,686.85**	Total Example Cost	**$5,601.10**	Total Example Cost	**$2,800.17**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$309.69
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Peg would pay is	**$309.69**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$402.98
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$402.98**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$530.00
Coinsurance	$39.60
What isn't covered	
Limits or exclusions	$211.56
The total Mia would pay is	**$781.16**

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
PRICE CHECK™

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).

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