



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 1-877-269-2134. 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 1-877-269-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In Network: \$0/Individual, \$0/Family	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: \$7,350/Individual, \$14,700/Family	The out-of-pocket limit is the most you could pay in a year for covered services. 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-billing charges, and health care this plan does not 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/contracts or call 1-877-269-2134 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
		In Network (You will pay the least)	Out of Network (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.	\$20 copayment /visit	Not Covered	You may use live video visits at www.doctorondemand.com .
	Specialist visit	\$20 copayment /visit	Not Covered	None
	Preventive care/screening /immunization	No Charge	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	\$20 copayment /visit	Not Covered	Copayment waived if performed at a designated laboratory/preferred center.
	Imaging (CT/PET scans, MRIs)	\$120 copayment /visit	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.cdphp.com/members/rx-corner/formulary-updates	Tier 1 drugs	Retail: \$4 copayment Mail order: \$8 copayment	Retail: Not Covered Mail order: Not Applicable	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.
	Tier 2 drugs	Retail: \$30 copayment Mail order: \$60 copayment	Retail: Not Covered Mail order: Not Applicable	
	Tier 3 drugs	Retail: \$60 copayment Mail order: \$120 copayment	Retail: Not Covered Mail order: Not Applicable	
	Specialty drugs	Retail: \$4 copayment / \$30 copayment / \$60 copayment	Not Covered	Drugs obtained at non-preferred retail pharmacies are subject to 50% coinsurance .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copayment /visit	Not Covered	You may have reduced cost share for preferred ambulatory surgery centers.
	Physician/surgeon fees	\$25 copayment /visit	Not Covered	None
If you need immediate medical attention	Emergency room care	\$100 copayment /visit	\$100 copayment /visit	All Emergency Care is considered In-Network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
	Emergency medical transportation	\$100 copayment /visit	\$100 copayment /visit	All Emergency Care is considered In-Network.
	Urgent care	\$50 copayment /visit	\$50 copayment /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)	\$750 copayment /stay	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copayment /visit	Not Covered	20 visits for family counseling.
	Inpatient services	\$750 copayment /stay	Not Covered	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost share applies for Initial visit to determine pregnancy, subsequent visits are Covered in Full.
	Childbirth/delivery professional services	No Charge	Not Covered	None
	Childbirth/delivery facility services	\$750 copayment /stay	Not Covered	None
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 40 visits per year
	Rehabilitation services	\$20 copayment /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.
	Habilitation services	\$20 copayment /visit	Not Covered	60 visits per condition, per Plan Year for PT/OT/ST services combined.
	Skilled nursing care	\$750 copayment /stay	Not Covered	365 days per year
	Durable medical equipment	50% coinsurance	Not Covered	Limited to 1 prosthetic device, per limb, per lifetime, with repairs. Orthotics and shoe inserts are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network (You will pay the least)	Out of Network (You will pay the most)	
	Hospice services	\$20 copayment /visit	Not Covered	Limited to 210 days per year
If your child needs dental or eye care	Children's eye exam	\$20 copayment /visit	Not Covered	One child routine eye exam per benefit period
	Children's glasses	50% coinsurance	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 .)		
• Cosmetic surgery	• Long-term care	• Private-duty nursing
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture 10 visits per benefit period	• Hearing aids	• Weight loss programs
• Bariatric surgery	• Infertility treatment	
• 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 1-877-269-2134 (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? 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.

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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	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$750
■ Other copayment	\$20

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,400

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$750
■ Other copayment	\$20

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,000
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,000

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$20
■ Hospital (facility) copayment	\$750
■ Other copayment	\$20

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$40
What isn't covered	
Limits or exclusions	\$200
The total Mia would pay is	\$840

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

FAIR HEALTH

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>

