**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.healthcare.gov/sbc-glossary or call 1-800-777-2273 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In Network: $3,250/Individual, $6,500/Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | Deductible does not apply to Preventive care/screening/immunization, telemedicine program. | This plan covers some items and services even if you haven't yet met the annual 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: $8,500/Individual, $17,000/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 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?** | 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. | $25 copayment/visit | Not Covered | None |
| | Specialist visit | $50 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) | $50 copayment/visit | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | $150 copayment/visit | Not Covered | None |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **www.cdphp.com** | Tier 1 drugs | Retail: $10 copayment<br>Mail order: $25 copayment | Retail: Not Covered<br>Mail order: Not Covered | Covers up to a 90-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. |
| | Tier 2 drugs | Retail: $50 copayment<br>Mail order: $125 copayment | Retail: Not Covered<br>Mail order: Not Covered | |
| | Tier 3 drugs | Retail: $80 copayment<br>Mail order: $200 copayment | Retail: Not Covered<br>Mail order: Not Covered | |
| | Specialty drugs | Retail: $10 copayment/ $50 copayment/ $80 copayment | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $200 copayment/visit | Not Covered | None |
| | Physician/surgeon fees | $100 copayment/visit | Not Covered | None |
| | Emergency room care | $500 copayment/visit | $500 copayment/visit | None |

| 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 need immediate medical attention** | Emergency medical transportation | $500 copayment/visit | $500 copayment/visit | All Emergency Care is considered In-Network. |
| | Urgent care | $75 copayment/visit | $75 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) | $1,500 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 | $25 copayment/visit | Not Covered | 20 visits for family counseling. |
| | Inpatient services | $1,500 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 | $1,500 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 | $50 copayment/visit | Not Covered | 60 visits per condition, per Plan Year for PT/OT/ST services combined. |
| | Habilitation services | $50 copayment/visit | Not Covered | 60 visits per condition, per Plan Year for PT/OT/ST services combined. |
| | Skilled nursing care | $1,500 copayment/stay | Not Covered | 365 days per year |
| | Durable medical equipment | 50% coinsurance | Not Covered | None |
| | Hospice services | $25 copayment/visit | Not Covered | Limited to 210 days per year |

| 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 your child needs dental or eye care** | Children's eye exam | $25 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 | None |

## 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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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 year
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)
- Weight loss programs

**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: 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 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?** **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.*

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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 | $3,250 |
| Specialist copayment | $50 |
| Hospital (facility) copayment | $1,500 |
| Other copayment | $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)*

| **Total Example Cost** | **$12,700** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,250 |
| Copayments | $1,500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$4,750** |

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

| | |
|---|---|
| The plan's overall deductible | $3,250 |
| Specialist copayment | $25 |
| Hospital (facility) copayment | $1,500 |
| Other copayment | $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)*

| **Total Example Cost** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $3,250 |
| Copayments | $400 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$3,650** |

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

| | |
|---|---|
| The plan's overall deductible | $3,250 |
| Specialist copayment | $50 |
| Hospital (facility) copayment | $1,500 |
| Other copayment | $25 |

**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** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $2,600 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Mia would pay is** | **$2,800** |