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. Please read the FEHB Plan brochure ([insert brochure number]) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure**. Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at www.cdphp.com/members/health-plan/nys-federal-government/federal-employee-health-plans/overview and view the Glossary at www.healthcare.gov/sbc-glossary. You can call 518-641-3140 or 1-877-269-2134 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 350/Self Only $ 700/Self Plus One $ 700/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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?	Yes. Preventive care, primary care and specialty services, diagnostic services, prescriptions, urgent care, and others.	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 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?	$ 8,550/Self Only $17,100/Self Plus One ($8,550 maximum per covered individual) $17,100/Self and Family ($8,550 maximum per covered individual)	The out-of-pocket limit, or catastrophic maximum, 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?	Copayments for certain services, premiums, balance-billing 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/findadoc 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40/visit	Not Covered	None.
	Specialist visit	$60/visit	Not Covered	None.
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$60/visit	Not Covered	Copayment waived at preferred site.
	Imaging (CT/PET scans, MRIs)	$60/visit	Not Covered	Copayment waived at preferred site.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	$10/Retail 30 Days $25/Mail Order 90 Days	Not Covered	Maximum of $400 per prescription for Tier 2 drugs and $600 per prescription for Tier 3 drugs. Member cost share will apply toward the annual out-of-pocket maximum. You must fill the prescription at a plan pharmacy, or mail order for a maintenance medication. Prescriptions filled at a participating pharmacy are limited to a 30-day supply. Approved maintenance prescriptions can be refilled through the mail for a 90-day supply. Prescription drugs listed on CDPHP's specialty pharmacy list must be obtained at CDPHP's
	Preferred brand drugs	50% Coinsurance Retail/Mail Order	Not Covered	
	Non-preferred brand drugs	50% Coinsurance Retail/Mail Order	Not Covered	
	Specialty drugs	50% Coinsurance Retail/Mail Order	Not Covered	

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, plus you may be balance billed)	
				participating specialty pharmacy for up to a 30-day supply, upon approval from CDPHP.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/visit after deductible	Not Covered	None.
	Physician/surgeon fees	No Charge	Not Covered	None.
If you need immediate medical attention	Emergency room care	$150/visit after deductible	$150/visit after deductible	Copayment waived if admitted to hospital within 24 hours for the same accident or injury.
	Emergency medical transportation	$100/trip after deductible	$100/trip after deductible	None.
	Urgent care	$60/visit	Not Covered.	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 per confinement + 20% coinsurance after deductible	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40/visit	Not Covered	None.
	Inpatient services	$500 per confinement + 20% coinsurance after deductible	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
If you are pregnant	Office visits	$40 copayment for initial visit only	Not Covered	None.
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	None.
	Childbirth/delivery facility services	$500 per confinement + 20% coinsurance after deductible	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Prior authorization by CDPHP Resource Coordination is required.
	Rehabilitation services	$60/visit	Not Covered	Physical, speech, and occupational therapy are limited to up to 2 months for each specific diagnosis and related condition per calendar year.

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, plus you may be balance billed)	
	Habilitation services	$60/visit	Not Covered	Covered for diagnosis of Autism.
	Skilled nursing care	$500 per confinement + 20% coinsurance after deductible	Not Covered	Limit of 90 days per calendar year. 2 copayments max per individual per year, or 3 copayments max per family per year.
	Durable medical equipment	50% coinsurance after deductible	Not Covered	Must be preauthorized if cost is over $1,000 or item is rented.
	Hospice services	No Charge	Not Covered	Limit of 210 days per calendar year for inpatient and outpatient combined.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	Eye exams through age 17 to determine the need for vision correction. Limited to one every 24 months.
	Children's glasses	50% coinsurance after deductible	Not Covered	Eyeglasses or contact lenses necessitated by certain medical conditions.
	Children's dental check-up	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure 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 US
- Private Duty Nursing
- Weight Loss Programs

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

- Acupuncture (Limitations Apply)
- Bariatric Surgery (Limitations Apply)
- Chiropractic Care (Limitations Apply)
- Hearing Aids (Limitations Apply)
- Infertility Treatment (Limitations Apply)
- Routine Eye Care – Adult (Limitations Apply)
- Routine Foot Care (Limitations Apply)

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-638-6589 or visit www.opm.gov/healthcare-insurance/healthcare/. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse

equity coverage, or temporary continuation of coverage (TCC). 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 www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: CDPHP Customer Service Department in writing at 500 Patroon Creek Blvd., Albany, NY 12206 or by calling 518-641-3140 or 1-877-269-2134.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]
[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 [insert telephone number].]
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

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	$350
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$350
Copayments	$530
Coinsurance	$1,182
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,062**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	0%
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*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$480
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$680**

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

The plan's overall deductible	$350
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	0%
Other *[cost sharing]*	0%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$350
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.