



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 73-549 at <https://www.cdphp.com/members/health-plan/nys-federal-government/federal-employee-health-plans/overview> and view the Glossary at <https://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 <u>deductible</u> ?	\$ 0 / Self Only \$ 0 / Self Plus One \$ 0 / Self and Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. All covered services.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$ 5,000/Self Only \$ 8,500/Self Plus One (\$5,000 per covered individual) \$8,500/Self and Family (\$5,000 per covered individual)	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance billed charges, health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.findadoc.cdphp.com">www.findadoc.cdphp.com</a> or call 1-877-269-2134 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . If you use a <u>network provider</u> , this plan will pay some or all of the costs for covered services. Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .





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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit	Not Covered	None.
	<u>Specialist</u> visit	\$40/visit	Not Covered	None.
	<u>Preventive care/screening/immunization</u>	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.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	\$40/visit	Not Covered	Copayment waived at preferred site.
	Imaging (CT/PET scans, MRIs)	\$40/visit	Not Covered	Copayment waived at preferred site.
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://www.caremark.com/wps/myportal/CHECK_DRUG_COST_FAST">https://www.caremark.com/wps/myportal/CHECK_DRUG_COST_FAST</a>	Generic drugs	\$10/30 day retail supply \$25/90 day Mail Order	Not Covered	Maximum of \$400 per prescription for Tier 2/3 drugs. Member cost share will apply toward the annual out of pocket maximum. You must fill the prescription at a <u>plan</u> pharmacy, or mail 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 participating specialty pharmacy for up to a 30-day supply, upon approval from CDPHP.
	Preferred brand drugs	30% Coinsurance Retail/Mail Order	Not Covered	
	Non-preferred brand drugs	30% Coinsurance Retail/Mail Order	Not Covered	
	<u>Specialty drugs</u>	30% Coinsurance	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100/visit	Not Covered	None.
	Physician/surgeon fees	No Charge	Not Covered	None.
<b>If you need immediate medical attention</b>	Emergency room care	\$150/visit	\$150/visit	Copayment waived if admitted to hospital within 24 hours for the same accident or injury.
	<u>Emergency medical transportation</u>	\$100/trip	\$100/trip	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, plus you may be balance billed)	
	<u>Urgent care</u>	\$40/visit	Not Covered	None.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 per confinement + 10% <u>coinsurance</u>	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
	Physician/surgeon fees	10% <u>coinsurance</u>	Not Covered	None.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25/visit	Not Covered	None.
	Inpatient services	\$500 per confinement + 10% <u>coinsurance</u>	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
<b>If you are pregnant</b>	Office visits	\$25 copayment for initial visit	Not Covered	No charge after initial diagnosis.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	Not Covered	None.
	Childbirth/delivery facility services	\$500 per confinement + 10% <u>coinsurance</u>	Not Covered	2 copayments max per individual per year, or 3 copayments max per family per year.
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	No Charge	Not Covered	Prior authorization by CDPHP Resource Coordination is required.
	<u>Rehabilitation services</u>	\$40/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.
	<u>Habilitation services</u>	Not covered	Not Covered	Covered for diagnosis of autism.
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	Not Covered	Limit of 90 days per calendar year.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not Covered	Must be preauthorized if cost is over \$500 or item is rented.
	<u>Hospice services</u>	No Charge	Not Covered	Limit of 210 days per calendar year for inpatient and outpatient combined.
<b>If your child needs dental or eye care</b>	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% <u>coinsurance</u>	Not Covered	Eyeglasses or contact lenses necessitated by certain medical conditions.

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)	
	Children's dental check-up	Not Covered	Not Covered	None.

**Excluded Services & Other Covered Services:**

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long Term Care</li> <li>• Non-emergency Care when Traveling Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private Duty Nursing</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)		
<ul style="list-style-type: none"> <li>• Acupuncture (Limitations apply)</li> <li>• Bariatric Surgery (Limitations apply)</li> <li>• Chiropractic Care (Limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing Aids (Limitations apply)</li> <li>• Infertility Treatment (Limitations apply)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care – Adult (Limitations apply)</li> <li>• Routine Foot Care (Limitations apply)</li> </ul>

**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 518-641-3140 or 1-877-269-2134, or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). 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 receive 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](http://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 plan's FEHB 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**

**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 1-800-777-2273

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-777-2273

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-777-2273

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-777-2273

---

*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)

■ <b>Specialist <u>copayment</u></b>	\$25
■ <b>Hospital (facility) <u>copayment</u></b>	\$500
■ <b>Other <u>coinsurance</u></b>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$525
Coinsurance	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,125</b>

### Managing Joe's type 2 Diabetes

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

■ <b>Specialist <u>copayment</u></b>	\$25
■ <b>Hospital (facility) <u>copayment</u></b>	\$500
■ <b>Other <u>coinsurance</u></b>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$480</b>

### Mia's Simple Fracture

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

■ <b>Specialist <u>copayment</u></b>	\$40
■ <b>Hospital (facility) <u>copayment</u></b>	\$500
■ <b>Other <u>coinsurance</u></b>	20%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

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

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$310
Coinsurance	\$40
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$350</b>