Pending Department of Financial Services approval

2027 CDPHP® Individual Health Plan Rate Sheet

REGION 1 (Albany)

Monthly premium rates vary by region, based on the county in which you live. Region 1 (Albany area) includes the following counties: Albany, Columbia, Greene, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, and Washington.

Important Note: To purchase a CDPHP health plan from the NY State of Health™ Individual Marketplace, and to check eligibility for tax credits and other cost-saving plan options, visit **www.nystateofhealth.ny.gov** or call **1-855-355-5777**.

	MEDICAL PLANS										
	PLATINUM			GOLD		SILVER			BRONZE		
	10 Standard HMO Copayment	**13** HMO Hybrid	**14** HMO Copayment	**20** Standard HMO Copayment	**24** HMO Triple Zero	**30** Standard HMO Copayment***	**33** HDHMO HSA-Qualified	**35** HDHMO HSA-Qualified	**44** HDHMO HSA-Qualified	**45** HDHMO HSA-Qualified	**60** Standard HDHMO HSA-Qualified**
Aggregate/Embedded Deductible	N/A	Embedded	N/A	Embedded	N/A	Embedded	Aggregate	Aggregate	Aggregate	Embedded	Embedded
In-Network Deductible (Single/Family)	$0/$0	$200/$400	$0/$0	$1,200/ $2,400	$0/$0	$3,750/ $7,500	$3,750/ $7,500	$3,250/ $6,500	$6,750/ $13,500	$7,800/ $15,600	$5,025/ $10,050
PCP Office Visit	$15	$15	$0	$25	$0 EPC/$60 PCP	$30***	15%	$25	30%	0%	$50**
Specialist Visit	$35	$20	$30	$40	$60	$65***	15%	$50	30%	0%	$75**
Inpatient Hospital	$500	10%	$500	$1,000	$1,600	$1,500	15%	$1,500	30%	0%	$1,500
Outpatient Surgery	$100	10%	$200	$100	$260	$150	15%	$200	30%	0%	$150
ER/Ambulance	$100	10%	$200	$150	$600	$500/$150	15%	$500	30%	0%	$500/$300
Prescription Drug (Tier 1/Tier 2/Tier 3)	$10/$30/$60	$1/10%/40%	$5/$15/$45	$10/$35/$70	$0/$50/$80	$15/$40/$75	$4/50%/50%	$10/$50/$80	50%/50%/50%	0%/0%/0%	$10/$35/$70
Out-of-Pocket Max (Single/Family)	$4,000/ $8,000	$6,000/ $12,000	$4,000/ $8,000	$12,000/ $24,000	$11,000/ $22,000	$12,000/ $24,000	$7,500/ $15,000	$8,500/ $17,000	$8,000/ $16,000	$7,800/ $15,600	$12,000/ $24,000
MONTHLY RATES											
Plan Code	**IHPF1573**	**IHPF1569**	**IHPF1571**	**IHGF2561**	**IHGF3810**	**IHSF5621**	**IHSF5525**	**IHSF5529**	**IHBF4576**	**IHBF4578**	**IHBF4582**
Subscriber Only	$1,606.39	$1,560.17	$1,629.08	$1,355.39	$1,388.09	$1,098.09	$1,068.46	$1,071.94	$827.75	$828.24	$851.16
Subscriber + Spouse/ Domestic Partner	$3,212.77	$3,120.35	$3,258.16	$2,710.79	$2,776.18	$2,196.18	$2,136.92	$2,143.89	$1,655.50	$1,656.49	$1,702.32
Subscriber + Child(ren)	$2,730.86	$2,652.30	$2,769.43	$2,304.17	$2,359.76	$1,866.75	$1,816.38	$1,822.31	$1,407.17	$1,408.01	$1,446.97
Family	$4,578.20	$4,446.50	$4,642.88	$3,862.87	$3,956.06	$3,129.55	$3,045.11	$3,055.04	$2,359.08	$2,360.49	$2,425.81
Subscriber + Child(ren) + Dependent Through 29	$2,740.51	$2,661.66	$2,779.23	$2,312.26	$2,368.05	$1,873.24	$1,822.69	$1,828.63	$1,411.98	$1,412.83	$1,451.93
Family + Dependent Through 29	$4,594.38	$4,462.19	$4,659.29	$3,876.43	$3,969.97	$3,140.43	$3,055.68	$3,065.65	$2,367.15	$2,368.56	$2,434.12

*** First three visits to PCP or specialist (total) not subject to the deductible*

**** One PCP or specialist visit not subject to deductible*

See the next page for information about Pediatric Dental Coverage.

Essential Pediatric Dental Coverage

To make health care more accessible, the Affordable Care Act (ACA) requires that all individual health plans provide coverage for a range of core services known as Essential Health Benefits (EHBs), one of which is pediatric dental care. To ensure that CDPHP members are covered appropriately, we are providing the essential coverage through a pediatric plan offered by Delta Dental of New York, Inc. (Delta Dental). On the CDPHP Enrollment Application, you are asked if you and any applicable dependents are receiving the essential pediatric coverage. If you answer no, we will enroll you and applicable dependents in the pediatric plan through Delta Dental. You will be billed for all enrolled individuals (subscribers and dependents) who are 18 years of age or younger. See below for details about the pediatric plan offered through Delta Dental and the rates that apply.

Monthly Rate Per Individual <19:

$21.56

Monthly pediatric plan rates are valid for effective dates:

January 1, 2027 through December 1, 2027.

The Delta Dental Pediatric Dental Plan offers the Delta Dental PPO℠ dental provider network. Visit www.deltadentalins.com to search for a dental provider.

Pediatric Dental Coverage through Delta Dental of New York

	Plan 70
Diagnostic	100%
Preventive	100%
Basic Restorative	50%
Oral Surgery	50%
Endodontics	50%
Periodontics	50%
Major Restorative	50%
Prosthodontics	50%
Implants	0%
TMJ (temporomandibular joint)	50%
Orthodontics	50%*
Annual out-of-pocket maximum per Individual	$450 for PPO providers/No maximum for Premier or non-participating providers**
Annual out-of-pocket maximum per 2+ Individual	$900 for PPO providers/No maximum for Premier or non-participating providers**
Annual Maximum per person	N/A
Lifetime TMJ Maximum per person	N/A
Ortho Maximum	N/A
Deductible/patient	$65
Deductible/person	N/A
Deductible/family	N/A
Deductible waived for D&P	No
Max waived for D&P	N/A
Copayment	N/A

** 12-month waiting period applies. Orthodontic services are covered for medical necessity only.*

*** Diagnostic and preventive services do not contribute to the annual maximum.*

***Note:** Percentages are based on Delta Dental's applicable maximum plan allowance or dentist's actual fee, whichever is less.*

Multi-language Interpreter Services

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).

注意：如果您使用的語言不是英語，您可以免費獲得語言援助服務。請致電您會員ID卡上的電話（聽力障礙電傳：711）。