
 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, contact CDPHP at 518-641-3100 for medical benefits and OptumRx at 866-863-1408 for prescription drugs. 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 1-800-269-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	CDPHN In-Network: None Out-of-Network: Individual \$250 / Family \$500	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 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 services are covered before you meet your deductible .	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet a deductible for specific services; see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	CDPHN In-Network: None CDPHN Out-of-Network: Individual \$2,500 / Family \$5,000	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 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 or call (518) 641-3100 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 do not need a referral to see a specialist.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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
		CDPHN In-Network	CDPHN Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment	Deductible, then 20% coinsurance	None
	Specialist visit	\$20 copayment	Deductible, then 20% coinsurance	None
	Preventive care/screening/immunization	No charge	Deductible, then 20% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. * Adult well exam only covered In-Network.
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full	Deductible, then 20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	\$20 copayment	Deductible, then 20% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com . If you have questions regarding whether your pharmacy participants please contact OptumRx at (866) 863-1408.	Generic drugs	20% for first three fills at Retail; 35% thereafter. 20% at Mail order.	You pay 100% of the cost and must submit a direct claim paper form to OptumRx for reimbursement. Reimbursement is based on network pricing and days supply, minus the applicable member coinsurance.	Covers up to 34-day supply (Retail); up to 90-day supply (Mail Order)
	Preferred brand drugs	20% for first three fills at Retail; 35% thereafter. 20% at Mail order.		
	Non-preferred brand drugs	30% for first three fills at Retail; 45% thereafter. 30% at Mail order.		
	Specialty drugs	Subject to Generic and Formulary Brand Status		Must use OptumRx Specialty Pharmacy. Specialty medications are dispensed using OptumRx Specialty Pharmacy with coinsurance proration.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		CDPHN In-Network	CDPHN Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copayment	Deductible, then 20% coinsurance	Preauthorization may be required. Covered in full at St. Mary's Healthcare.
	Physician/surgeon fees	Covered in full	Deductible, then 20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$100 copayment	\$100 copayment	Copay waived if admitted to the same hospital within 24 hours.
	Emergency medical transportation	\$50 copayment	\$50 copayment	None
	Urgent care	\$35 copayment	\$35 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copayment / stay	Deductible, then 20% coinsurance	Preauthorization is required. If you don't get preauthorization , benefits could be reduced.
	Physician/surgeon fees	Covered in full	Deductible, then 20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	\$5 Copayment	Deductible, then 20% coinsurance	None
	Mental/Behavioral health inpatient services	\$250 copayment / stay	Deductible, then 20% coinsurance	
	Substance use disorder outpatient services	\$10 Copayment	Deductible, then 20% coinsurance	
	Substance use disorder inpatient services	\$250 copayment / stay	Deductible, then 20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		CDPHN In-Network	CDPHN Out-of-Network	
If you are pregnant	Office visits	\$20 copayment	Deductible, then 20% coinsurance	Copay applies to initial physician visit only.
	Childbirth/delivery professional services	Covered in full	Deductible, then 20% coinsurance	None
	Childbirth/delivery facility services	\$250 copayment	Deductible, then 20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	\$10 copayment	Deductible, then 20% coinsurance	200 visits per calendar year; Aggregate INN & OON; Prior authorization is required.
	Rehabilitation services	\$10 copayment	Deductible, then 20% coinsurance	CDPHN In-Network: Max 60 days combined for PT/OT/ST.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	\$250 copayment	Deductible, then 20% coinsurance	120 days per calendar year; Aggregate INN & OON; within 30 days of discharge from hospital; Prior authorization is required.
	Durable medical equipment	20% coinsurance	Deductible, then 20% coinsurance	Prior authorization required for items in excess of \$500.
	Hospice services	\$10 copayment	Deductible, then 20% coinsurance	210 days per calendar year; Combined INN & OON. Includes 5 bereavement visits. Prior authorization is required.
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	None
	Children's glasses	No Charge	No Charge	One pair per Calendar year. You will be reimbursed up to \$300 every calendar year. See SPD for additional information.
	Children's dental check-up	20% coinsurance	20% coinsurance	Administered by Delta Dental

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
- Private Duty Nursing (Outpatient)
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Foot Care
- Acupuncture

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Bariatric Surgery
- Chiropractic Care
- Private Duty Nursing (Inpatient)
- Infertility Treatment
- Dental Care
- Routine eye care (Adult)
- Hearing Aids

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: 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: 1-877-724-2579 or visit us at www.cdphp.com.

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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, kwijigo 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](#) \$0
- [Specialist copayment](#) \$20
- [Hospital \(facility\) copayment](#) \$250
- Other [coinsurance](#) 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	\$12,840
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$270
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$340

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](#) \$250
- Other [coinsurance](#) 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	\$7,460
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$200
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	1,400

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](#) \$250
- Other [coinsurance](#) 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*)

Total Example Cost	\$2,010
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles*	\$0
Copayments	\$240
Coinsurance	\$10
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$250

*Note: This plan has other [deductibles](#) for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.