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 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	Covered in full	Deductible, then 20% coinsurance	MRA/MRI, PET Scans take a $20 copay. All other imaging is covered in full.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CDPHP.com	Generic drugs	Not Covered.	Not Covered.	Carved out to Optum RX.
	Preferred brand drugs	Not Covered.	Not Covered.	
	Non-preferred brand drugs	Not Covered.	Not Covered.	
	Specialty drugs	Not Covered.	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$50 copayment	Deductible, then 20% coinsurance	Preauthorization may be required.
	Physician/surgeon fees	Covered in full	Deductible, then 20% coinsurance	None

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 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	
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

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 need help recovering or have other special health needs	Home health care	$10 copayment	Deductible, then 20% coinsurance	100 visits per calendar year; Aggregate INN & OON; Prior authorization is required.
	Rehabilitation services	$10 copayment	Deductible, then 20% coinsurance	CDPHN In-Network: Max 30 days combined for PT/OT/ST.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	$250 copayment	Deductible, then 20% coinsurance	100 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 $1000.
	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	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
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- 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
- Infertility Treatment

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 1-877267-2323 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, 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	$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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$270
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$270**

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$80**

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	**$2,400**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$140
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$180**

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

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