HMO : HM2L18 Coverage for: All Tiers | Plan Type: HMO

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, call 1-800-777-2273 . 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 1-800-777-2273 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this **plan** covers.
Are there services covered before you meet your deductible?	No.	See the Common Medical Events chart below for your costs for services this **plan** covers.
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?	In-Network: $7,350 individual/ $14,700 family.	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 billed** 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 1-800-777-2273 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?	Yes.	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 **co-pay** /visit	Not Covered	You may use live video visits at www.doctorondemand.com.
	Specialist visit	$50 **co-pay** /visit	Not Covered	Prior authorization required for sleep study(including apnea).
	Preventive care/screening/ immunization	No Charge	Not Covered	None.
If you have a test	Diagnostic test (x-ray, blood work)	$50 **co-pay** /visit	Not Covered	Copayment waived if performed at a designated laboratory/preferred center. Prior Authorization is required for Genetic Testing and High-Tech Radiology.
	Imaging (CT/PET scans, MRIs)	$50 **co-pay** /visit	Not Covered	Copayment waived if performed at a preferred center. Prior authorization required for high-tech imaging and services.

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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.cdphp.com/Members/Rx-Corner	Tier 1 drugs	Retail: $10 **copay** Mail-Order: $25 **copay**	Not Covered	Coverage is limited to Tier 1 Drugs only and covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Prescriptions must be written by a duly licensed health care provider and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP. Coverage for specialty drugs is limited to Tier 1 drugs only. Specialty drugs are not eligible for the mail order program and require preauthorization to be obtained through CDPHP's participating specialty vendors. This plan has Formulary 1 and the Premier Rx Network.
	Tier 2 drugs	Retail: Not Covered Mail-Order: Not Covered	Not Covered	
	Tier 3 drugs	Retail: Not Covered Mail-Order: Not Covered	Not Covered	
	Specialty drugs	Retail: $10 **copay** /Not Covered/Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 **co-pay** /visit	Not Covered	You may have reduced cost share for preferred ambulatory surgery centers.
	Physician/surgeon fees	No Charge	Not Covered	Secure authorization before bariatric surgery or you may owe an additional 50% payment.
If you need immediate medical attention	Emergency room care	$100 **co-pay** /visit	$100 **co-pay** /visit	All Emergency Care is considered In-Network.
	Emergency medical transportation	$100 **co-pay** /visit	$100 **co-pay** /visit	All Emergency Care is considered In-Network.
	Urgent care	$35 **co-pay** /visit	$35 **co-pay** /visit	Urgent Care from Non-Participating Urgent Care Centers in Our Service Area are not covered. You may use **live video visits**.
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 **co-pay** /visit	Not Covered	Prior authorization required for continuous confinement services and inpatient stays.
	Physician/surgeon fees	No Charge	Not Covered	Secure authorization before bariatric surgery or you may owe an additional 50% payment.

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 **co-pay** /visit	Not Covered	None.
	Inpatient services	$1,000 **co-pay** /visit	Not Covered	None.
If you are pregnant	Office visits	$50 **co-pay** /visit	Not Covered	Cost share applies for Initial visit to determine pregnancy, subsequent visits are Covered in Full
	Childbirth/delivery professional services	No Charge	Not Covered	None.
	Childbirth/delivery facility services	$1,000 **co-pay** /visit	Not Covered	None.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	If you do not secure authorization before receiving care, you can be held responsible for an additional payment of 50% of the allowed amount, up to $500 per service, in addition to your usual cost-share.
	Rehabilitation services	$1,000 **co-pay** /visit	Not Covered	60 consecutive inpatient days per plan year for PT/OT/ST services. Secure authorization before receiving care, or you may be responsible for additional payments of 50% of the allowed amount (up to $500 per service), in addition to cost-share.
	Habilitation services	$30 **co-pay** /visit	Not Covered	Limited to coverage for Applied Behavioral Analysis when necessary for the treatment of Autism Spectrum Disorder. All contract limits and provisions for managed benefits apply.

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)	
	Skilled nursing care	$1,000 **co-pay** /visit	Not Covered	Limited to 45 days per benefit period.
	Durable medical equipment	50% **co-insurance**	Not Covered	Prior authorization required for Left Ventribular Assist Device (LVAD). Shoe inserts are not covered.
	Hospice services	No Charge	Not Covered	Limited to 210 days combined Inpatient and Outpatient.
If your child needs dental or eye care	Children's eye exam	$50 **co-pay** /visit	Not Covered	One routine eye exam is covered every 24 months.
	Children's glasses	Not Covered after plan allowance	Not Covered after plan allowance	CDPHP will pay up to the following amount- Frames and Lenses, $75. Contact Lenses, $75. One pair of frames and lenses or contact lenses is allowed every 24 months.
	Children's dental check-up	Not Covered	Not Covered	Preventive Dental is not covered under your medical benefits.

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 (Adult) • Dental checkup • Glasses • Hearing aids • Long term care	• Non-emergency care when traveling outside the U.S. • Private-duty nursing • Routine foot care • Specialty Drug Coverage • Tier 2 Drug Coverage • Tier 3 Drug Coverage • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture (Limits Apply) • Bariatric surgery (Limits Apply) • Chiropractic care	• Infertility treatment (21-44 years old) • Routine eye care (Adult)

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 as follows: Contact CDPHP at 1-800-777-2273 (or TTY 711),The New York State of Health NYS Department of Financial Services at (800) 342-3736 or **http://www.dfs.ny.gov/**, the Health Insurance Assistance Team of the U.S. Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or **www.cciio.cms.gov**, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html**.

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: CDPHP at 1-800-777-2273 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or **http://www.dfs.ny.gov/**, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or **www.dol.gov/ebsa/healthreform**.

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 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.

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	**N/A**
Specialist *cost sharing*	**$50.00**
Hospital (facility) *cost sharing*	**$1,000.00**
Other *cost sharing*	**N/A**

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	$12,731.28

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1032.90
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$60.04
The total Peg would pay is	**$1092.94**

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

The plan's overall deductible	**N/A**
Specialist *cost sharing*	**$50.00**
Hospital (facility) *cost sharing*	**$1,000.00**
Other *cost sharing*	**N/A**

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	$7,389.29

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$1881.72
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$0.00
The total Joe would pay is	**$1881.72**

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

The plan's overall deductible	**N/A**
Specialist *cost sharing*	**$50.00**
Hospital (facility) *cost sharing*	**$1,000.00**
Other *cost sharing*	**N/A**

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	$1,925.04

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0.00
Copayments	$450.00
Coinsurance	$36.88
What isn't covered	
Limits or exclusions	$162.00
The total Mia would pay is	**$648.88**

Estimate how much doctors and dentists in your area charge for services
www.fairhealthconsumer.org
FAIRHEALTH

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

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

Discrimination is Against the Law

Capital District Physicians' Health Plan, Inc. (CDPHP®) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

If you believe that CDPHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), Fax (518) 641-3401. You can file a grievance by mail, fax, or electronically at https://www.cdphp.com/customer-support/email-cdphp. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201,
1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Multi-language Interpreter Services

ATTENTION: If you speak a non-English language, language assistance services, free of charge, are available to you. Call the number on your member ID card (TTY: 711).

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）。

ВНИМАНИЕ: Если вы говорите на иностранном языке, вы можете воспользоваться бесплатными услугами перевода. Позвоните по номеру на вашей ID карточке участника (Телетайп: 711).

ATANSYON: Si ou pale yon lang ki pa Angle, wap jwenn sèvis asistans lang gratis disponib pou ou. Rele nimewo ki sou kat ID manm ou a (TTY: 711).

주의: 영어 이외의 언어를 사용하는 경우 무료로 언어 지원 서비스를 받을 수 있습니다. 귀하의 회원 ID 카드에 있는 번호로 전화하십시오(TTY: 711).

ATTENZIONE: Se non parla inglese né una lingua anglofona, sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero presente sulla scheda ID dei membri (TTY: 711).

אויפמערקזאם: אויב איר רעדט , זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט דעם נומער אויף אייער מעמבער ID קארטל (711:TTY)

মনোযোগ দিনঃ আপনি যদি ইংরেজি বহির্ভুত কোন ভাষায় কথা বলেন ,আপনার জন্য বিনা খরচায় ভাষা সহায়তা উপলভ্য রয়েছে। আপনার সদস্য আইডি কার্ডের নম্বরে কল করুন (TTY: 711(।

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer na Twojej członkowskiej karcie ID (TTY: 711).

تنبيه: إذا كنت تتحدث لغة غير الإنجليزية، تتوفر إليك خدمات مساعدة اللغة مجانًا. اتصل بالرقم الموجود ببطاقة الهوية لعضويتك (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez au numéro indiqué sur votre carte de membre (ATS : 711).

توجہ دیں: اگر آپ انگریزی کے علاوہ دوسری زبان بولتے ہیں تو، آپ کے لیے زبان کی اعانت کی خدمات مفت دستیاب ہیں۔ اپنے ممبر آئی ڈی کارڈ پر درج نمبر پر کال کریں (TTY: 711)۔

ATENSYON: Kung nagsasalita kayo ng wikang iba sa Ingles, magagamit niyo ang mga serbisyo sa tulong sa wika nang walang bayad. Tawagan ang numero sa inyong card miyembro ID (TTY: 711).

ΠΡΟΣΟΧΗ: Αν δεν μιλάτε Αγγλικά, υπάρχουν στη διάθεσή σας υπηρεσίες γλωσσικής υποστήριξης οι οποίες παρέχονται δωρεάν. Καλέστε τον αριθμό που θα βρείτε στην ατομική σας ταυτότητα μέλους (TTY: 711).

VINI RE: Nëse flisni një gjuhë jo-anglisht, shërbime falas të ndihmës së gjuhës janë në dispozicion për ju. Telefonojini numrit në kartën tuaj të ID të anëtarit (TTY: 711).