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 1-877-269-2134. 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 1-877-269-2134 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>What is the overall <strong>deductible</strong>?</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network: $0 individual. Out-of-Network: $0 individual.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
<td></td>
</tr>
</tbody>
</table>

| Are there services covered before you meet your **deductible**? | **Deductible** does not apply to preventive care, certain diabetic services, and prescription drugs. | 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |

| 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: $6,350 individual. Out-of-Network: $6,350 individual. | 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 1-877-269-2134 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 can see the specialist you choose without a referral. |

*If applicable, you may be able to use your Flexible Spending Account and/or your Health Reimbursement Arrangement to cover these costs. Refer to the Summary Plan Description and Plan Document for more information.
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
<td>You may use live video visits at <a href="http://www.doctorondemand.com">www.doctorondemand.com</a>.</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
<td>Preauthorization required for Sleep Studies, Neurofeedback &amp; Transcranial Magnetic Stimulation (TMS)</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>$15 copay; 10% co-ins</td>
<td>Preauthorization required for Genetic Testing and Immunizations for RSV.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
<td>Preauthorization required for Genetic Testing. Coinsurance waived if performed at a designated laboratory/preferred center.</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
<td>In-Network Coinsurance waived if performed at a preferred center.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 drugs</td>
<td>Retail: 10% coins</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail-Order: 10% coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 2 drugs</td>
<td>Retail: 10% coins</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail-Order: 10% coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 3 drugs</td>
<td>Retail: 10% coins</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mail-Order: 10% coins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Retail: 10% coins</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$100 copay; 10% co-ins</td>
<td>You may have reduced cost share for preferred ambulatory surgery centers.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$100 copay; 10% co-ins</td>
<td>All Emergency Care is considered In-Network.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% co-insurance/visit</td>
<td>All Emergency Care is considered In-Network.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copay; 10% co-ins</td>
<td>You may use <strong>live video visits</strong>.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% co-insurance/visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>----------------------------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Inpatient services</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No Charge</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>No Charge</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery facility services</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Rehabilitation services</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>10% co-insurance/visit</td>
<td>10% co-insurance</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>$15 copay; 10% co-ins</td>
<td>$15 copay; 10% co-ins</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| - Cosmetic surgery  
- Dental care (Adult)  
- Dental checkup  
- Eye exam  
- Glasses  
- Long term care |
| - Private-duty nursing  
- Routine eye care (Adult)  
- Routine foot care  
- Weight loss programs |

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
</table>
| - Acupuncture (Limits Apply)  
- Bariatric surgery (Limits Apply)  
- Chiropractic care |
| - Infertility treatment  
- Non-emergency care when traveling outside the U.S. |
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 1-877-269-2134 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or [http://www.dfs.ny.gov/](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](http://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](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 1-877-269-2134 (or TTY 711), The New York State of Health NYS Department of Financial Services at (800) 342-3736 or [http://www.dfs.ny.gov/](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](https://www.dol.gov/ebsa/healthreform).

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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.
### 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** is $0.00.
- **Specialist cost sharing** is $15;10%.
- **Hospital (facility) cost sharing** is 10%.
- **Other cost sharing** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$522.90</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**The total Peg would pay is** $522.90

---

### Managing Joe’s type 2 Diabetes

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

- The **plan's overall deductible** is $0.00.
- **Specialist cost sharing** is $15;10%.
- **Hospital (facility) cost sharing** is 10%.
- **Other cost sharing** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1656.72</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0.00</td>
</tr>
</tbody>
</table>

**The total Joe would pay is** $1656.72

---

### Mia’s Simple Fracture

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

- The **plan's overall deductible** is $0.00.
- **Specialist cost sharing** is $15;10%.
- **Hospital (facility) cost sharing** is 10%.
- **Other cost sharing** is 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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0.00</td>
</tr>
<tr>
<td>Copayments</td>
<td>$275.00</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$36.88</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$162.00</td>
</tr>
</tbody>
</table>

**The total Mia would pay is** $473.88

---

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).


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（聽力障礙電話：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 mamn 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).

APOTREPO: Αοτρ σε Φράγκι και βουλευτικά διαμέσους, σε χάρη της ελεύθερης υπηρεσίας της Ελληνικής σημαίας, θα καθοδηγούμε τα ενδιαφέροντα σας δικαιώματα. Συνεπάγεται τη δέσμευση να διαδραματίσετε στο πλαίσιο της περιοδείας (TTY: 711).

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

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).