This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cdphp.com or by calling 1-877-269-2134

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-Network: **$500** individual/**$1,000** family. Deductible does not apply to preventive care, prescription drugs, DME, and certain diabetic services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-Network **$2,000** individual/**$4,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.cdphp.com or call 1-877-269-2134** for a list of participating providers.	If you use an in-network doctor or health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See our policy or plan document for additional information about **excluded services**.

Questions: Call 1-877-269-2134 or visit us at www.cdphp.com
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cdphp.com or call 1-877-269-2134.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost		Limitations & Exceptions
		In-network	Out-of-network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 co-pay/visit	Not Covered	None.
	Specialist visit	$50 co-pay/visit	Not Covered	None.
	Other practitioner office visit	$50 co-pay/visit for chiropractor	Not Covered	Acupuncture is not covered under this plan.
	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	Deductible does not apply and Copayment waived if performed at a designated laboratory/preferred center.
	Imaging (CT/PET scans, MRIs)	$50 co-pay/visit	Not Covered	Deductible does not apply and Copayment waived if is performed at a preferred center.

Common Medical Event	Services You May Need	Your cost		Limitations & Exceptions
		In-network	Out-of-network	
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: $4 copay Mail-Order: $10 copay	Not Covered	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. Specialty drugs are not eligible for the mail order program and require preauthorization to be obtained through CDPHP's participating specialty vendors.
	Tier 2 drugs	Retail: 50% coinsurance Mail-Order: 50% coinsurance	Not Covered	
	Tier 3 drugs	Retail: 50% coinsurance Mail-Order: 50% coinsurance	Not Covered	
	Specialty drugs	Retail: $4 copay/50% coinsurance/50% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance	Not Covered	You may have reduced cost share for preferred ambulatory surgery centers.
	Physician/surgeon fees	No Charge	Not Covered	None.
If you need immediate medical attention	Emergency room services	20% co-insurance	20% co-insurance	All Emergency Care is considered In-Network.
	Emergency medical transportation	20% co-insurance	20% co-insurance	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.

Common Medical Event	Services You May Need	Your cost		Limitations & Exceptions
		In-network	Out-of-network	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance	Not Covered	None.
	Physician/surgeon fee	No Charge	Not Covered	None.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 co-pay/visit	Not Covered	None.
	Mental/Behavioral health inpatient services	20% co-insurance	Not Covered	None.
	Substance use disorder outpatient services	$25 co-pay/visit	Not Covered	Up to 20 visits a plan year may be used for Family Counseling.
	Substance use disorder inpatient services	20% co-insurance	Not Covered	None.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	None.
	Delivery and all inpatient services	20% co-insurance	Not Covered	None.
	Home health care	$25 co-pay/visit	Not Covered	Limited to 40 visits per plan year. 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	20% co-insurance	Not Covered	60 visits per condition, per lifetime combined therapies. 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.

Common Medical Event	Services You May Need	Your cost		Limitations & Exceptions
		In-network	Out-of-network	
If you need help recovering or have other special health needs	Habilitation services	$50 co-pay/visit	Not Covered	680 hours per plan year for ABA services at PCP copay. 60 visits per condition, per lifetime, combined for PT/OT/ST therapies.
	Skilled nursing care	20% co-insurance	Not Covered	Limited to 200 days per plan year. 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.
	Durable medical equipment	50% co-insurance	Not Covered	Durable medical equipment that is rented, repaired, replaced or costs more than $500 requires you to secure authorization before receiving care, otherwise 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.
	Hospice service	20% co-insurance	Not Covered	Limited to 210 days per plan year.
If your child needs dental or eye care	Eye exam	$25 co-pay/visit	Not Covered	One routine eye exam per benefit period.
	Glasses	50% co-insurance	Not Covered	Coverage is limited to "Standard" eyeglasses.
	Dental check-up	Not Covered	Not Covered	Preventive Dental is not covered under your medical benefits.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Dental checkup
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (Limits Apply)
- Chiropractic care
- Hearing aids
- Infertility treatment (21-44 years old)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-877-269-2134.

You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact 1-877-269-2134 . You can also contact the State Department of Financial Services at 1-800-342-3736 or visit www.dfs.ny.gov.

Additionally, a consumer assistance program can help you file your appeal. Contact 1-(888)-614-5400 or visit http://www.communityhealthadvocates.org.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage meets the minimum value standard for the benefits it provides.**

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays : $6,406**
- **Patient pays : $1,134**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Co-pays	$47
Co-insurance	$587
Limits or exclusions	$0
Total	**$1,134**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays : $4,325**
- **Patient pays : $1,075**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$1,075
Co-insurance	$0
Limits or exclusions	$0
Total	**$1,075**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

Costs don't include **premiums**.

Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.

The patient's condition was not an excluded or preexisting condition.

All services and treatments started and ended in the same coverage period.

There are no other medical expenses for any member covered under this plan.

Out-of-pocket expenses are based only on treating the condition in the example.

The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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