UBI : UNION518 Coverage for: All Tiers | Plan Type: PPO

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	Answers	Why This Matters:
What is the overall deductible?	In-Network: $0 individual. Out-of-Network:$400 individual.	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?	**Deductible** does not apply to **preventive care**, office based services, **durable medical equipment** and diabetic services.	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 **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	In-Network: $5,000 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.**

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	$25 **co-pay** /visit	$40 **co-pay** /visit	You may use live video visits at www.doctorondemand.com.
	Specialist visit	$25 **co-pay** /visit	$40 **co-pay** /visit	Prior authorization required for sleep study(including apnea).
	Preventive care/screening/ immunization	No Charge	$40 **co-pay** /visit	None.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% **co-insurance**	Prior Authorization is required for Genetic Testing and High-Tech Radiology.
	Imaging (CT/PET scans, MRIs)	No Charge	30% **co-insurance**	When services are out-of-network and 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. 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	$10 copay	20% **co-insurance**	None.
	Tier 2 drugs	$45 copay	20% **co-insurance**	
	Tier 3 drugs	$75 copay	20% **co-insurance**	
	Specialty drugs	$75 copay	20% **co-insurance**	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% **co-insurance**	30% **co-insurance**	None.
	Physician/surgeon fees	No Charge	30% **co-insurance**	None.
If you need immediate medical attention	Emergency room care	10% **co-insurance**	10% coinsurance	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 **copay**	30% coinsurance	You may use **live video visits**.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	30% **co-insurance**	When services are out-of-network and 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. Prior authorization required for continuous confinement services.
	Physician/surgeon fees	No Charge	30% **co-insurance**	None.

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	$25 **co-pay** /visit	$40 **co-pay** /visit	None.
	Inpatient services	10% coinsurance	30% **co-insurance**	None.
If you are pregnant	Office visits	$25 **co-pay** /visit	$40 **co-pay** /visit	Cost share applies for Initial visit to determine pregnancy, subsequent visits are Covered in Full
	Childbirth/delivery professional services	No Charge	30% **co-insurance**	None.
	Childbirth/delivery facility services	10% coinsurance	30% **co-insurance**	None.
If you need help recovering or have other special health needs	Home health care	10% **co-insurance**	30% **co-insurance**	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	10% coinsurance	30% **co-insurance**	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	$25 **co-pay** /visit	$40 **co-pay** /visit	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	10% coinsurance	30% **co-insurance**	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	10% **co-insurance**	30% **co-insurance**	Durable medical equipment that is rented, repaired, replaced or costs more than $500 requires prior 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. Prior authorization required for Left Ventribular Assist Device. Shoe inserts are not covered.
	Hospice services	10% coinsurance	30% **co-insurance**	Limited to 210 days combined Inpatient and Outpatient.
If your child needs dental or eye care	Children's eye exam	No Charge	30% **co-insurance**	None.
	Children's glasses	No Charge	30% **co-insurance**	None.
	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
- Eye exam
- Glasses
- Long term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- 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)
- 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/**, 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** l. 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/**, 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	**$0.00**
Specialist *cost sharing*	**$25.00**
Hospital (facility) *cost sharing*	**$50.00**
Other *cost sharing*	**10%**

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	$50.00
Coinsurance	$19.80
What isn't covered	
Limits or exclusions	$96.32
The total Peg would pay is	**$166.12**

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

The plan's overall deductible	**$0.00**
Specialist *cost sharing*	**$25.00**
Hospital (facility) *cost sharing*	**$50.00**
Other *cost sharing*	**10%**

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	$1478.18
Coinsurance	$0.00
What isn't covered	
Limits or exclusions	$319.02
The total Joe would pay is	**$1797.20**

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

The plan's overall deductible	**$0.00**
Specialist *cost sharing*	**$25.00**
Hospital (facility) *cost sharing*	**$50.00**
Other *cost sharing*	**10%**

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	$225.00
Coinsurance	$35.98
What isn't covered	
Limits or exclusions	$162.00
The total Mia would pay is	**$422.98**

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).