

# CDPHP<sup>®</sup> PPO Plan Benefit Summary



Plan Code: BLKTCAZENO20 (Pending NYS DFS Approval)  
 Presented For: Cazenovia College Student Plan  
 Group ID: 20030040  
 Date Prepared: 2/19/2020  
 Effective Date: 08/18/2020

	In-Network	Out-Network
<b>Cost Sharing Information-</b>		
<b>coinsurance not mentioned</b>		
<u>Deductible</u>	\$100 Single	\$200 Single
<u>Out of Pocket Maximum</u>	\$5,000 Single	\$10,000 Single
<b>Office Visits</b>		
<u>PCP</u>	\$15 Copayment	Deductible then 30% Coinsurance
<u>Live Video Doctor Visits (24/7 Sick Visits, Behavioral Health, Telenutrition)</u>	\$15 Copayment	Not Covered
<u>Specialist</u>	\$15 Copayment	Deductible then 30% Coinsurance
<b>Preventive and Well Care Services*</b>		
<u>Well Baby and Child Care including immunizations - last year was simply immunizations and inoculations, not specific to kids</u>	Covered in full	Deductible then 30% Coinsurance
<u>Annual Adult Exam (One exam per plan year regardless if 365 days have passed)</u>	Covered in full	Deductible then 30% Coinsurance
<u>Mammography</u>	Covered in full	Deductible then 30% Coinsurance
<u>Annual Pap Test and Ob/Gyn Exam</u>	Covered in full	Deductible then 30% Coinsurance
<u>Prostate Cancer Screening</u>	Covered in full	Deductible then 30% Coinsurance
<u>Bone Density Tests - new</u>	Covered in full	Deductible then 30% Coinsurance
*Cost sharing may apply to diagnostic care		
<b>Hospital Services</b>		
<u>Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)</u>	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
<u>Outpatient Surgery</u> * Cost share may be reduced at a preferred ambulatory surgery center.	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
<b>Maternity Services*</b>		
<u>Maternity - Routine Prenatal Care and Postnatal Care</u>	Covered in Full*	Deductible then 30% Coinsurance
<u>Maternity - Inpatient Hospital Services</u>	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
<u>Newborn Nursery</u>	Deductible then Covered in full	Deductible then 30% Coinsurance
*(Non-routine services may result in an additional cost share)		
<b>Emergency Care</b>		
<u>Worldwide Emergency Room Care (waived if admitted inpatient)</u>	\$100 Copayment, then 10% Coinsurance	All Emergency Care is Considered In Network
<u>Ambulance</u>	Deductible then 10% Coinsurance	All Emergency Care is Considered In Network
<b>Urgent Care</b>		
<u>Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered</u>	\$15 Copayment	Deductible then \$15 Copayment
<b>Diagnostic Testing*</b>		
<u>Outpatient Hospital or Office Based Laboratory Services</u> * <u>Deductible does not apply and Coinsurance waived if provider is a preferred laboratory.</u>	Covered in full	Deductible then 30% Coinsurance
<u>Outpatient Hospital or Office Based Radiology Services</u> * <u>Coinsurance waived if provider is a preferred center.</u>	Covered in full	Deductible then 30% Coinsurance
<b>Behavioral Health Services - includes detox</b>		
<u>Mental Health/Substance Use Inpatient Services</u>	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
<u>Mental Health/Substance Use Outpatient Services</u>	\$15 Copayment	Deductible then 30% Coinsurance
*(Up to 20 visits per plan year may be used for family counseling without the patient for substance use)		
<b>Condition Support Services</b>		

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<u>Outpatient Rehabilitation/ Habilitation Services - Physical Therapy</u>	\$15 Copayment (60 visits combined PT/OT/ST per benefit period)	Deductible then 30% Coinsurance (See In-Network limitation)
<u>Outpatient Rehabilitation/ Habilitation Services - Speech Therapy</u>	\$15 Copayment (60 visits combined PT/OT/ST per benefit period)	Deductible then 30% Coinsurance (See In-Network limitation)
<u>Outpatient Rehabilitation/ Habilitation Services - Occupational Therapy</u>	\$15 Copayment (60 visits combined PT/OT/ST per benefit period)	Deductible then 30% Coinsurance (See In-Network limitation)
<u>Home Health Care</u>	Covered in full	Deductible then 30% Coinsurance
<u>Skilled Nursing Facility</u>	Deductible then 10% Coinsurance (200 days per benefit period)	Deductible then 30% Coinsurance (See In-Network limitation)
<u>Chemotherapy/Radiation Therapy visit</u>	\$15 Copayment	Deductible then 30% Coinsurance
<u>Prosthetic Appliances and Durable Medical Equipment</u>	Deductible then 20% Coinsurance	Deductible then 30% Coinsurance
<b>Diabetic Services</b>		
<u>Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME</u>	Deductible then 10% Coinsurance	Deductible then 30% Coinsurance
<b>Vision Services</b>		
<u>Laser Eye Surgery</u>	Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime	
<b>Wellness Care</b>		
<u>Weight Management</u>	Up to a \$75 reimbursement available for participation in a weight loss program	
<u>Fitness Reimbursement- didn't description</u>	Up to \$200 reimbursement per 50 visits for subscriber (max \$400 reimbursement per year)	
<u>Child Birthing Classes - new</u>	Up to \$75 reimbursement available for completion of child birthing class	
<u>CaféWell Participation - different description</u>	Participating (Up to \$365 Life Points per contract per calendar year)	
<u>Acupuncture (10 visit limit per plan year for acupuncture services)</u>	\$15 Copayment	Deductible then 30% Coinsurance
<u>Nutritional Counseling-new</u>	\$15 Copayment	Deductible then 30% Coinsurance
<u>Chiropractic Benefits</u>	\$15 Copayment	Deductible then 30% Coinsurance

*This Summary of Benefits is intended to provide a general outline of coverage. In the event of any conflict between this document and the member's Certificate and any applicable Rider(s) issued by CDPHP, the Certificate and Rider(s) will be the controlling documents.*

*All benefits of this plan are subject to coordination of benefits. This summary is designed to highlight benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. For more detailed information, a membership Certificate is available for your review upon request.*

*CDPHP UBI gives you access to more than 825,000 participating practitioners and providers nationwide, including many of the major hospitals, and a variety of value-added services to help you and your family stay healthy. If you have a question or wish to receive additional information, please contact the CDPHP marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at [www.cdphp.com](http://www.cdphp.com).*

*Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc.<sup>®</sup> (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI. Please Note. All non-emergency services must be provided by a CDPHP Universal Benefits, Inc.<sup>®</sup> (CDPHP UBI) Participating Physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.*

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## Pharmacy Coverage

### Retail Prescription Drugs (30 Day Supply)

Tier 1 Drugs	\$10
Tier 2 Drugs	\$25
Tier 3 Drugs	\$40
Specialty Drugs	\$40

Description

Mail order, 2.5 copayments for a 90-day supply. 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. Prescription drugs are not subject to the plan deductible, if applicable.