Saratoga Hospital: EPO $500

Coverage for: Family | **Plan Type:** EPO

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, contact CDPHP at 518-641-3100. 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 1-800-269-2134 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Domestic: $0 Albany Med Health System Network: **$250** Individual / **$500** Two person & Family In-Network: **$500** Individual / **$1000** Two person & Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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?	Yes. Preventive care services are covered before you meet your deductible.	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 a deductible for specific services; see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Domestic: $0 Albany Med Health System Network: **$1,500** Individual / **$3,000** Two person & Family In-Network: **$3,000** Individual / **$6,000** Two person & Family	The out-of-pocket limit is the most you could pay in a year for covered services. 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-billing 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 (518) 641-3100 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 do not need a referral to see a 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	Domestic: $0 Albany Med Health System Network: $15 copay In-Network: $30 copay	Not Covered.	None
	Specialist visit	Domestic: $0 Albany Med Health System Network: $30 copay In-Network: $40 copay	Not Covered.	None
	Preventive care/screening/ immunization	No charge	Not Covered.	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Domestic: $0 Albany Med Health System Network: 10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	None
	Imaging (CT/PET scans, MRIs)	Domestic: $0 Albany Med Health System Network: 10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.CDPHP.com	Generic drugs (Tier 1)	$10 copay/prescription (retail & mail order)	Not Covered.	Covers up to a 30-day supply retail subscription; 90 day supply mail order prescription applies copay x 2.5. Specialty drugs (Tier 5): 37.5% coinsurance after deductible (max of $150 for 30 day supply)
	Preferred brand drugs (Tier 2)	$40 copay/prescription (retail & mail order)	Not Covered.	
	Non-preferred brand drugs (Tier 3)	$55 copay/prescription (retail & mail order)	Not Covered.	
	Specialty drugs (Tier 4)	25% coinsurance after deductible (max of $150 for 30 day supply)	Not Covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Domestic: $0 Albany Med Health System Network: 10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	Preauthorization may be required.

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)	
	Physician/surgeon fees	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	None.
If you need immediate medical attention	Emergency room care	Domestic:$100 copay/visit Albany Med Health System Network:$100 copay/visit In-Network:$150 copay/visit	All Emergency Room Visits are considered to be In-network.	None
	Emergency medical transportation	Domestic: N/A Albany Med Health System Network: N/A In-Network:$100 copay/visit	All Emergency Room Visits are considered to be In-network.	
	Urgent care	Domestic: $0 Albany Med Health System Network:$25 copay/visit In-Network $75 copay/visit	Not Covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Domestic: $0 Albany Med Health System Network:10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
	Physician/surgeon fees	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Domestic: $0 Albany Med Health System Network: $15 PCP copay In-Network $30 PCP copay	Not Covered.	None
	Inpatient services	Domestic: $0 Albany Med Health System Network:10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	
If you are pregnant	Office visits	Covered in full	Not Covered.	A copay will apply to the initial office visit to determine pregnancy.

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)	
	Childbirth/delivery professional services	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	
	Childbirth/delivery facility services	Domestic: $0 Albany Med Health System Network:10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	
If you need help recovering or have other special health needs	Home health care	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	Based on medical necessity
	Rehabilitation services	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	30 visits annually for physical and occupational therapy. Speech Therapy covered 20 visits annually.
	Habilitation services	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	
	Skilled nursing care	Domestic: $0 Albany Med Health System Network: $15 PCP/$30 Specialist copay In-Network $30 PCP/$40 Specialist copay	Not Covered.	Based on medical necessity
	Durable medical equipment	Domestic: $0 Albany Med Health System Network: 10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization required for items in excess of $1000.

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)	
	Hospice services	Domestic: $0 Albany Med Health System Network: 10% coinsurance after deductible In-Network: 20% coinsurance after deductible	Not Covered.	210 days combined inpatient and outpatient. Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered by Vision Carrier.
	Children's glasses	Not covered	Not covered	Covered by Vision Carrier.
	Children's dental check-up	Not covered	Not covered	Covered by Dental Carrier.

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
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- NYS Autism Mandate
- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- NYS IVF Mandate

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: 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 1-877267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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: 1-877-724-2579 or visit us at www.cdphp.com.

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 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-724-2579
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-724-2579
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-724-2579
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-724-2579

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	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$90
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2590**

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

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$240
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1140**

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

The plan's overall deductible	$500
Specialist copayment	$40
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$500
Copayments	$30
Coinsurance	$450
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

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