

# CDPHP<sup>®</sup> EPO Copay First Plan Benefit Summary

Marketing Plan ID: 425  
 Plan Code: SUBF4420  
 Effective Date: 1/1/2019



<b>Copay First Accumulator</b>	Your cost share plus the amount CDPHP pays. Once \$3,000/\$6,000 (Single/Family) in shared cost have been met, claims are subject to the deductible. (Aggregate)
<b>Copay First Phase (Phase 1)</b>	Copayment applies to services until maximum allowed charges are met.
<b>Deductible Phase (Phase 2)</b>	All services are subject to the deductible (not including ACA preventive care)
<b>Copayment After Deductible Phases (Phase 3)</b>	Copayment applies for all services after deductible is met, until Out of Pocket Maximum is met.

	<b>Phase 1 Cost-Share</b>	<b>Phase 2 &amp; 3 Cost-Share</b>
<b>Deductible</b>	N/A	\$6,000 Single / \$12,000 Family (Embedded)
<b>Out of Pocket Maximum</b>	\$6,850 Single / \$13,700 Family (Embedded)	See Phase 1
<b>Coinsurance</b>	Not Applicable	Not Applicable
<b>Office Visits</b>		
PCP	\$30 Copayment	Deductible then \$30 Copayment
Live Video Doctor Visits	\$30 Copayment	Deductible then \$30 Copayment
Specialist	\$50 Copayment	Deductible then \$50 Copayment
<b>Physician Services</b>		
PCP Office Visits for illness, injury or second opinion	\$30 Copayment	Deductible then \$30 Copayment
Specialist Office Visits for illness, injury or second opinion	\$50 Copayment	Deductible then \$50 Copayment
Physician Visits during inpatient stay when billed separately from the facility	Covered in full	Deductible then Covered in full
Chemotherapy/Radiation Therapy (See also Prescription Drugs Administered in Office section)	\$30 Copayment	Deductible then \$30 Copayment
Well Baby and Child Care including immunizations and inoculations	Covered in full	Covered in full
Annual Adult Exam	Covered in full	Covered in full
Annual Gynecological Exam	Covered in full	Covered in full
<b>Retail Pharmacy</b>		
*Medical plan deductible does not apply to preventive prescription drugs.		
Tier 1 Drugs	\$10 Copayment	Deductible then \$10 Copayment
Tier 2 Drugs	\$30 Copayment	Deductible then \$30 Copayment
Tier 3 Drugs	\$50 Copayment	Deductible then \$50 Copayment
Specialty Drugs	\$50 Copayment	Deductible then \$50 Copayment
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. This plan uses the Premier network and Formulary 2.		
<b>Mail Order</b>		
*Medical plan deductible does not apply to preventive prescription drugs.		
Tier 1 Mail Order Drugs	\$25 Copayment	Deductible then \$25 Copayment
Tier 2 Mail Order Drugs	\$75 Copayment	Deductible then \$75 Copayment
Tier 3 Mail Order Drugs	\$125 Copayment	Deductible then \$125 Copayment
<b>Prescription Drugs Administered in Office or Outpatient Facilities</b>		
PCP Office cost share	20% Coinsurance	Deductible then 20% Coinsurance

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	Phase 1 Cost-Share	Phase 2 & 3 Cost-Share
Specialist Office cost share	20% Coinsurance	Deductible then 20% Coinsurance
Outpatient Facility cost share	20% Coinsurance	Deductible then 20% Coinsurance
<b>Hospital Services</b>		
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	\$500 Copayment	Deductible then \$500 Copayment
Newborn Nursery	Covered in full	Deductible then Covered in full
Outpatient Surgery * Cost share may be reduced at a preferred ambulatory surgery center.	\$75 Copayment	Deductible then \$75 Copayment
<b>Emergency Care</b>		
Worldwide Emergency Room Care	\$75 Copayment	Deductible then \$75 Copayment
Ambulance	\$75 Copayment	Deductible then \$75 Copayment
<b>Urgent Care</b>		
Nonparticipating urgent care facility services within the CDPHP UBI service area are not covered	\$60 Copayment	Deductible then \$60 Copayment
<b>Diagnostic Testing*</b>		
Outpatient Hospital Laboratory Services * Copayment waived if provider is a designated laboratory.	\$50 Copayment	Deductible then \$50 Copayment
Outpatient Hospital Radiology Services * Copayment waived if provider is a preferred center.	\$50 Copayment	Deductible then \$50 Copayment
Office Based Laboratory Services * Copayment waived if provider is a designated laboratory.	\$50 Copayment	Deductible then \$50 Copayment
Office Based Radiology Services * Copayment waived if provider is a preferred center.	\$50 Copayment	Deductible then \$50 Copayment
Mammogram	Covered in full	Covered in full
Cytology Screening	Covered in full	Covered in full
Prostate Cancer Screening	Refer to PCP or Specialist Cost-Share Based on Place of Service	Deductible then Refer to PCP or Specialist Cost-Share Based on Place of Service
<b>Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>		
(60 visits per condition per plan year combined therapies for OT, PT, ST)	\$50 Copayment	Deductible then \$50 Copayment
<b>Home Health Care</b>		
(40 visits per benefit period)	\$30 Copayment	Deductible then \$30 Copayment
<b>Skilled Nursing Facility</b>		
(365 days per plan year)	\$500 Copayment	Deductible then \$500 Copayment
<b>Prosthetic Appliances and Durable Medical Equipment</b>		
	50% Coinsurance	Deductible then 50% Coinsurance
<b>Diabetic Services</b>		
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME	\$30 Copayment	Deductible then \$30 Copayment
<b>Mental Health Services</b>		
Inpatient	\$500 Copayment	Deductible then \$500 Copayment
Outpatient	\$30 Copayment	Deductible then \$30 Copayment
<b>Chemical Abuse and Dependency Services</b>		
Inpatient (Detoxification/Rehabilitation)	\$500 Copayment	Deductible then \$500 Copayment
Outpatient (Up to 20 visits a plan year may be used for Family Counseling without the patient.)	\$30 Copayment	Deductible then \$30 Copayment
<b>Vision Services</b>		

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	Phase 1 Cost-Share	Phase 2 & 3 Cost-Share
Adult Vision Exam (One exam per plan year.)	\$50 Copayment	Deductible then \$50 Copayment
Adult Glasses/Contacts	Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement.	Deductible then See Phase 1
Pediatric Vision Exam (One exam per plan year.)	\$30 Copayment	Deductible then \$30 Copayment
Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames.)	50% Coinsurance	Deductible then 50% Coinsurance
Laser Eye Surgery	Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime	See Phase 1
<b>Wellness Care</b>		
Weight Management	\$75 reimbursement available for participation in a weight loss program.	See Phase 1
Acupuncture (10 visit limit for acupuncture services)	\$50 Copayment	Deductible then \$50 Copayment
Chiropractic Benefits	\$50 Copayment	Deductible then \$50 Copayment
<b>Fitness Reimbursement</b>	\$600 total reimbursement available \$200 subscriber/\$100 spouse every 6-months	See Phase 1
<b>Dependent Coverage</b>	Covered to Age 26	See Phase 1
<b>Domestic Partner Coverage</b>	Covered	See Phase 1
<b>CaféWell Participation</b>	Participating (Up to \$180 points per contract).	See Phase 1

*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.*

*Preauthorization requests are your responsibility. Failure to obtain a required Preauthorization for certain services may result in a penalty of the lesser of \$500 or 50% of the service. Please refer to your certificate for a listing of services requiring preauthorization.*