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 1-877-724-2579 (Medical benefits) or Express Scripts (Pharmacy benefits) at 1-877-800-4034. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-518-262-8414 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Tier 1** – Albany Med Health System Network: $0 Individual / $0 Family; **Tier 2** – CDPHN/Express Scripts Network: $1,000 Individual / $2,000 Family; **Tier 3** – Out-of-Network: $2,000 Individual / $4,000 Family	Generally, you must pay all of the costs from providers (including pharmacies) 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 is 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	**Tier 1** – Albany Med Health System Network: $1,000 Individual / $2,000 Family; **Tier 2** – CDPHN/Express Scripts Network: $4,000 Individual / $8,000 Family; **Tier 3** – Out-of-Network: $8,000 Individual / $15,000 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, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.CDPHP.com or www.Express-Scripts.com/AlbanyMedHealthSystem.com or call 1-877-724-2579 or 1-877-800-4034 for a list of network providers.	This plan uses a provider network. You generally pay the least if you use an Albany Med Health System Network provider. You may pay more if you use a CDPHN/Express Scripts Network provider. 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 Tier 1: Albany Med Health System Network	Tier 2: CDPHN / Express Scripts Network	Tier 3: Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Covered in full	$25 copayment	Deductible, then 30% coinsurance	None
	Specialist visit	Covered in full	$45 copayment	Deductible, then 30% coinsurance	None
	Preventive care/screening/ immunization	Covered in full	Covered in full	Covered in full	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. Routine Colonoscopy covered Out-of-Network at Deductible, then 50%coinsurance.
If you have a test	Diagnostic test (x-ray, blood work)	Covered in full	Deductible, then covered in full	Deductible, then 30%	None

[* For more information about limitations and exceptions, see the plan or policy document at www.AlbanyMed.HRintouch.com.]

		What You Will Pay			
Common Medical Event	**Services You May Need**	**Tier 1: Albany Med Health System Network**	**Tier 2: CDPHN / Express Scripts Network**	**Tier 3: Out-of-Network**	**Limitations, Exceptions, & Other Important Information**
	Imaging (CT/PET scans, MRIs)	Covered in full	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Pre-authorization required for out-of-network care. Benefits will be reduced by $300 if pre-authorization is not obtained. Subject to deductible.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Express-Scripts.com/AlbanyMedHealthSystem or 1-877-800-4034	Generic Drugs	$10 Copayment (30-day supply); $20 Copayment (31-60 Day Supply); $25 Copayment (61-90 day supply)	$20 Copayment (30-day supply)	Not Covered	Up to a 90-day supply of formulary medication may be obtained at the Albany Med Specialty/Outpatient Pharmacy and the Glens Falls Hospital Outpatient Pharmacy
	Preferred Brands	$50 Copayment (30-day supply); $100 Copayment (31-60 Day Supply); $125 Copayment (61-90 day supply)	$100 Copayment (30-day supply)	Not Covered	
	Non-Preferred Brands	$75 Copayment (30-day supply); $150 Copayment (31-60 Day Supply); $187.50 Copayment (61-90 day supply)	$150 Copayment (30-day supply)	Not Covered	
	Specialty Medication	Copayment Waived* (30-day Supply)	Copayment Waived* (30-day Supply)	Not Covered	*Must enroll in IPC Copay Assistance Program administered by PillarRx, otherwise 30% coinsurance
	Insulin	$20 Copayment	$20 Copayment	Not Covered	Up to a 90-day supply

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Need
		Tier 1: Albany Med Health System Network	Tier 2: CDPHN / Express Scripts Network	Tier 3: Out-of-Network	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	None
	Physician/surgeon fees	Covered in full	Deductible, then covered in full	Deductible, then 30% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 Copayment	$200 Copayment	$200 Copayment	Copayment waived if admitted within 24 hours.
	Emergency medical transportation	N/A	Deductible, then $50 Copayment	Deductible, then 30% coinsurance	None
	Urgent care	Covered in full	$75 copayment	Deductible, then 30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	Deductible, then 20% coinsurance ($300 copayment if admitted through Emergency Room)	Deductible, then 30% coinsurance	None
	Physician/ surgeon fees	Covered in full	Deductible, then Covered in full	Deductible, then 30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Covered in full	$25 copayment	Deductible, then 30% coinsurance	None
	Inpatient services	Covered in full	Deductible, then 20% coinsurance ($300 copayment if admitted through Emergency Room)	Deductible, then 30% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.AlbanyMed.HRintouch.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important information
		Tier 1: Albany Med Health System Network	Tier 2: CDPHN / Express Scripts Providers	Tier 3: Out of Network Providers	
If you are pregnant	Office visits	Covered in full	Covered in full	Deductible, then 30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayments may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Covered in full	Covered in full	Deductible, then 30% coinsurance	
If you need help recovering or have other special health needs	Home health care	Covered in full	$25 Copayment	Deductible, then 30% coinsurance	40 Visit Annual Out-of- Network Maximum. Pre- Authorization required for Out-of-Network
	Rehabilitation services	Covered in full	$45 Copayment	Deductible, then 30% coinsurance	60 Visits Combined In-and Out-of- Network
	Habilitation services	Not Covered	Not Covered	Not Covered	None
	Skilled nursing care	N/A	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	150-day lifetime maximum
	Durable medical equipment	10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 30% coinsurance	Prior authorization required for rented items and items in excess of $1,000
	Hospice services	N/A	Deductible, then covered in full	Deductible, then 30% coinsurance	90-day lifetime maximum
If your child needs dental or eye care	Children's eye exam	Covered in full	$45 Copayment	Not Covered	Limited to 1 exam every 2 calendar years
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

[* For more information about limitations and exceptions, see the plan or policy document at www.AlbanyMed.HRintouch.com.]

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)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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
- Bariatric surgery (Must be performed at Albany Med Health System Network Facility)
- Chiropractic care
- Infertility treatment (Limitations apply)
- Routine eye care (Adult) (Limitations apply)

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 on how 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 1-877-724-2579 or visit www.cdphp.com, www.caremark.com, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact (888) 614-5400 or visit http://www.communityhealthadvocates.org.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al [insert telephone number].]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[insert telephone number].]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number].]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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**
Specialist copayment	**$0**
Hospital (facility) copayment	**$0**
Lab & Imaging	**$0**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and bloodwork)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) copayment	**$0**
Durable medical equipment coins.	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$80
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$500**

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

The plan's overall deductible	**$0**
Specialist copayment	**$0**
Hospital (facility) copayment	**$0**
Emergency Room copayment	**$200**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles (ambulance)	$900
Copayments	$60
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,050**

Notes: Examples assume the patient has Individual coverage and uses Albany Med Health System Network Providers/Facilities when available. Costs under $100 are rounded to the nearest $10; costs over $100 are rounded to the nearest $100. The plan would be responsible for the other costs of these EXAMPLE covered services.