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 & **Tier 2:** CDPHN/Express Scripts Network: $1,600 Individual / $3,200 Family; **Tier 3:** Out-of- Network: $4,500 Individual/$9,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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?	For network providers (Albany Med Health System Network & CDPHN/Express Scripts Network): $4,000 individual / $8,000 family; for out-of-network providers $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, the overall family out-of-pocket limit must be 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.

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

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 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			Limitations, Exceptions, & Other Important Information
		Tier 1: Albany Med Health System Network	Tier 2: CDPHN/ Express Scripts Network	Tier 3: Out-of- Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Deductible, then $10 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None
	Specialist visit	Deductible, then $20 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None
	Preventive care/screening/ immunization	Covered in full	Covered in full	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. Routine Colonoscopy covered Out-of-Network at Deductible, then 50% coinsurance.
	Diagnostic test (x-ray, blood work)	Deductible, then Covered in Full	Deductible, then Covered in Full	Deductible, then 50% coinsurance	None

If you have a test	Imaging (CT/PET scans, MRIs)	Deductible, then $50 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	Pre-authorization required for out-of-network care. Benefits will be reduced by $300 if pre-authorization is not obtained.
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 Network**	**Tier 3: Out-of- Network**	
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	Deductible, then: $10 Copayment (30-day supply); $20 Copayment (31-60 day supply); $25 Copayment (61-90 day supply)	Deductible, then $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	Deductible, then: $50 Copayment (30-day supply); $100 Copayment (31-60 day supply); $125 Copayment (61-90 day supply)	Deductible, then $100 Copayment (30-day supply)	Not Covered	
	Non-Preferred Brands	Deductible, then: $75 Copayment (30-day supply); $150 Copayment (31-60 day supply); $187.50 Copayment (61-90 day supply)	Deductible, then $150 Copayment (30-day supply)	Not Covered	
	Specialty Medication	Deductible, then $100 Copayment (30-day supply)	Deductible, then $200 Copayment (30-day supply)	Not Covered	
	Insulin	Deductible, then $20 Copayment	Deductible, then $20 Copayment	Not Covered	Up to a 90-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then $50 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None

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 Network	Tier 3: Out-of- Network	
	Physician/surgeon fees	Deductible, then Covered in Full	Deductible, then Covered in Full	Deductible, then 50% coinsurance	None
If you need immediate medical attention	Emergency room care	Deductible, then $200 Copayment	Deductible, then $200 Copayment	Deductible, then $200 Copayment	None
	Emergency medical transportation	N/A	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None
	Urgent care	Deductible, then $20 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then $100 Copayment	Deductible, then 20% coinsurance ($100 copayment if admitted through Emergency Room)	Deductible, then 50% coinsurance	None
	Physician/surgeon fees	Deductible, then Covered in Full	Deductible, then Covered in Full	Deductible, then 50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then $10 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	None
	Inpatient services	Deductible, then $100 Copayment	Deductible, then 20% coinsurance ($100 copayment if admitted through Emergency Room)	Deductible, then 50% coinsurance	
If you are pregnant	Office visits	No Charge	No Charge	Deductible, then 50% 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	Deductible, then Covered in Full	Deductible, then Covered in Full	Deductible, then 50% coinsurance	
	Childbirth/delivery facility services	Deductible, then $100 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% 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 Network	Tier 3: Out-of-Network	
If you need help recovering or have other special health needs	Home health care	Deductible, then $10 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% coinsurance	40 Visit Annual Out-of-Network Maximum. Pre-Authorization required for Out-of-Network
	Rehabilitation services	Deductible, then $20 Copayment	Deductible, then 20% coinsurance	Deductible, then 50% 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 50% coinsurance	150-day lifetime maximum
	Durable medical equipment	Deductible, then 10% coinsurance	Deductible, then 20% coinsurance	Deductible, then 50% 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 50% coinsurance	90-day lifetime maximum
If your child needs dental or eye care	Children's eye exam	Deductible, then $20 Copayment	Deductible, then 20% coinsurance	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

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)

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

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.*

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	$1,600
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	10%

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	$1,600
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,670**

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

The plan's overall deductible	$1,600
Specialist copayment	$20
Hospital (facility) copayment	$100
Other coinsurance	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	$1,600
Copayments	$400
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,080**

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

The plan's overall deductible	$1,600
Specialist copayment	$20
Hospital (facility) copayment	$200
Other coinsurance	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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,820**

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.