**18The 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, call 1-877-724-2579. 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 or call 1-877-724-2579 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-Network: $400/Individual or $800/Family<br>Out-Of-Network: $800/Individual or $1,600/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. In-Network preventive care services and any service that takes a copay 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?** | In-Network: $2,000/Individual or $4,000/Family<br>Out-Of-Network: $4,000/Individual or $8,000/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, 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 1-877-724-2579 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). Plans use the term in-network, preferred, or participating providers in their network. See chart starting on page 2 for how this plan pays different kinds of providers. |
| **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 |
|---|---|---|---|---|
| | | 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 | $20 copay/visit | Deductible then 30% coinsurance | None |
| | Specialist visit | $30 copay/visit | Deductible then 30% coinsurance | In-Network: The specialist copayment decreases to $20 copay/visit after 10 cumulative specialty visits. |
| | Preventive care/screening/ immunization | No charge | Deductible then 30% coinsurance | None |
| **If you have a test** | Diagnostic test (x-ray, blood work) | $0 preferred, $20 copay/visit non-preferred | Deductible then 30% coinsurance | Diagnostic radiology and blood work is covered in full at a preferred facility. $20 copay/visit for non-preferred. |
| | Imaging (CT/PET scans, MRIs) | $0 free-standing, $100 copay/visit non-free-standing | Deductible then 30% coinsurance | High technology imaging is covered in full at a free-standing facility. $100 copay/visit applies in hospital setting. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.optumrx.com | Generic drugs (Tier 1) | 30-day supply: $10 copay<br>90-day supply:$20 copay | 30-day supply: $10 copay<br>90-day supply: $20 copay | Maintenance medications must be filled in a 90-day supply at OptumRx mail order or CVS pharmacy location after 3 grace fills. Specialty drugs must be filled at OptumRx's specialty pharmacy, BriovaRx. Prior authorization may be required. |
| | Preferred brand drugs (Tier 2) | 30-day supply: $30 copay<br>90-day supply:$60 copay | 30-day supply: $30 copay<br>90-day supply:$60 copay | |
| | Non-preferred brand drugs (Tier 3) | 30-day supply: $50 copay<br>90-day supply:$100 copay | 30-day supply: $50 copay<br>90-day supply:$100 copay | |
| | Specialty drugs | Tier 1, Tier 2, or Tier 3 cost share will apply | Tier 1, Tier 2, or Tier 3 cost share will apply | |



* For more information about limitations and exceptions, see the plan or policy document at www.CDPHP.com.

| 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 have outpatient surgery** | Facility fee (ambulatory surgery center) | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| | Physician/surgeon fees | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | $100 copay/visit | $100 copay/visit | Copay waived if admitted within 24 hours for same diagnosis for emergency room only. |
| | Emergency medical transportation | Deductible then 10% coinsurance | Deductible then 30% coinsurance | |
| | Urgent care | $25 copay/visit | Deductible then 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (hospital room) | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| | Physician/surgeon fees | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay/visit | Deductible then 30% coinsurance | In-Network: The specialist copayment decreases to $20 copay/visit after 10 cumulative specialty visits. |
| | Inpatient services | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| **If you are pregnant** | Office visits | $20 copay/visit | Deductible then 30% coinsurance | In-Network: Copay applies to first visit only. |
| | Childbirth/delivery professional services | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| | Childbirth/delivery facility services | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | $20 copay/visit | Deductible then 30% coinsurance | Prior authorization required. Must be medically necessary. |
| | Rehabilitation services | $20 copay/visit PCP<br>$30 copay/visit Specialist | Deductible then 30% coinsurance | 30 visit maximum per condition per calendar year combined in-network and out-of-network. In-Network: The specialist copayment decreases to $20 copay/visit after 10 cumulative specialty visits. |
| | Habilitation services | $30 copay/visit | Deductible then 30% coinsurance | In-Network: The specialist copayment decreases to $20 copay/visit after 10 cumulative specialty visits. |



* For more information about limitations and exceptions, see the plan or policy document at www.CDPHP.com.

| 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) | |
| | Skilled nursing care | Deductible then 10% coinsurance | Deductible then 30% coinsurance | None |
| | Durable medical equipment | Deductible then 20% coinsurance | Deductible then 50% coinsurance | Resource coordination authorization required for items rented and items over $500. |
| | Hospice services | Deductible then 10% coinsurance | Deductible then 30% coinsurance | Maximum 210 days combined inpatient and outpatient services per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | $20 copay/visit PCP<br>$30 copay/visit Specialist | Deductible then 30% coinsurance | In-Network: The specialist copayment decreases to $20 copay/visit after 10 cumulative specialty visits. 1 visit every 24 months for routine exam. |
| | Children's glasses | Not Covered | Not Covered | None |
| | Children's dental check-up | 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.)**

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult and Child)
- Long Term Care
- None-Emergency care when traveling outside the U.S.
- Weight Loss Programs
- Glasses
- Routine Foot Care

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

- Bariatric Surgery (Limitations Apply)
- Infertility Treatment
- Chiropractic Care
- Hearing Aids
- Routine Eye Care (Adult)
- Private Duty Nursing

**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: The U.S. Department of Labor, Employee Benefits Security Administration – 1-866-444-3272 or www.dol.gov/ebsa, The U.S. Department of Health and Human Services – 1-877-267-2323 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 CDPHP at 1-877-724-2579.

**Does this plan provide Minimum Essential Coverage?** **Yes.**



* For more information about limitations and exceptions, see the plan or policy document at www.CDPHP.com.

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 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 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.*



* For more information about limitations and exceptions, see the plan or policy document at www.CDPHP.com.

## 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** **$400**
- **Specialist *copay*** **$20**
- **Hospital (facility) *coinsurance*** **10%**
- **Other (Rx) *copay*** **$10**

**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** | **$12,731** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $140 |
| Coinsurance | $855.90 |
| *What isn't covered* | |
| Limits or exclusions | Childbirth classes |
| **The total Peg would pay is** | **$1,395.90** |

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

- **The plan's overall deductible** **$400**
- **Specialist *copay*** **$30**
- **Hospital (facility)** **N/A**
- **Other (PCP/Rx) *copay*** **$30**

**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** | **$7,389** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,440 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Joe would pay is** | **$1,440** |

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

- **The plan's overall deductible** **$400**
- **Specialist *copay*** **$30**
- **Hospital (facility) *copay*** **$100**
- **Other (DME) *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** | **$1,925** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $400 |
| Copayments | $370 |
| Coinsurance | $59.10 |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Mia would pay is** | **$829.10** |

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