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

Marketing Plan ID: 220Plan Code:SUGF3416Group ID:PROSPECTPresented For:PROSPECTDate Prepared:SU240101Metal Tier:GOLD



	In-Network
Cost Sharing Information	
Deductible	\$750 Single / \$1,500 Family (Embedded)
Dut of Pocket Maximum	\$8,700 Single / \$17,400 Family (Embedded)
Dependent Coverage	Covered to Age 26
Domestic Partner Coverage	Covered
Office Visits	
PCP	Deductible then \$25 Copayment
PCP Cost share waived for members that are under age of 19	
Specialist	Deductible then \$40 Copayment
Telemedicine	
Preferred Live Video Doctor Visits (aptihealth, Doctor on Demand, Foodsmart, MovN)	Covered in Full
Other Participating Telemedicine Providers (Valera)	Deductible then \$25 Copayment
Telehealth services from a CDPHP Network provider (PCP or Specialist)	PCP or Specialist cost share based on provid
Preventive and Well Care Services*	
Nell Baby and Child Care including immunizations	Covered in full
Annual Adult Exam (One exam per plan year regardless if 365 days have passed)	Covered in full
Mammography	Covered in full
Annual Pap Test and Ob/Gyn Exam	Covered in full
Prostate Cancer Screening	Covered in full
Bone Density Tests	Covered in full
Cost sharing may apply to diagnostic care	
Retail Prescription Drugs	
Medical plan deductible, if applicable, does not apply to prescription drugs.	
Preferred Tier 1 Drugs (*Tier 1 drug cost share waived for members that are under age of 19)	\$4 Copayment
Preferred Tier 2 Drugs	\$30 Copayment
Preferred Tier 3 Drugs	\$60 Copayment
Non-Preferred Tier 1 Drugs	50% Coinsurance
Non-Preferred Tier 2 Drugs	50% Coinsurance
Non-Preferred Tier 3 Drugs	50% Coinsurance
Specialty Drugs	\$60 Copayment
Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription). Mail order, 2.0 Preferred Tier Copayments for a 90 day supply. 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. This plan uses <u>CDPHP Formulary 2</u> .	
Hospital Services	
npatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	Deductible then \$800 Copayment
Outpatient Surgery Facility * Cost share may be reduced at a preferred ambulatory surgery center.	Deductible then \$100 Copayment
Outpatient Surgery - Surgeon's Services	Deductible then \$50 Copayment
Maternity Services*	
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*
Maternity - Inpatient Hospital Services	Deductible then \$800 Copayment
Newborn Nursery	Deductible then Covered in full
(Non-routine services may result in an additional cost share)	

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

Marketing Plan ID: 220Plan Code:SUGF3416Group ID:PROSPECTPresented For:PROSPECTDate Prepared:Effective Date:Effective Date:20240101Metal Tier:GOLD



Ambulance         Deductible then \$100 Copayment           Urgent Care         Menn aseking care within CDPHIP's Service Ares, a participating Urgent Care Center must be used.         Deductible then \$500 Copayment           Diagnostic Testing*         Deductible then \$500 Copayment         Deductible then \$500 Copayment           Diagnostic Testing*         Deductible gased Laboratory Services:         Deductible from 20% Coinsurance           CPD Office         Deductible from \$500 Copayment         Deductible from \$500 Copayment         Minital Health Services         Deductible from \$500 Copayment           Wheat Health Services         Deductible from \$500 Copayment         Deductible from \$500 Copayment         Minital Health Services         Deductible from \$500 Copayment           V(D) to 20 visits per plan year romay to used for substance use family counseling 1         Countert \$500 Copayment         Deductible from \$500 Copayment           V(D) to 20 visits per plan year romained mergines for OT, PT, ST)         Deductible from \$500 Copayment         Deductible from \$500 Copayment         Deductible from \$500 Copayment         D	Metal Her: GOLD	In-Network
Urgent Care When seeking care within CDPHP's Service Area, a participating Urgent Care Center must be used. Deductible then 580 Copayment Diagnostic Testing* Outpatient Hospital or Office Based Laboratory Services: Deductible then 540 Copayment Diagnostic Testing* D	Worldwide Emergency Room Care (waived if admitted inpatient)	Deductible then \$100 Copayment
When seeking care within CDPHP's Service Area, a participating Urgent Care Center must be used.         Deductible then \$40 Copayment           Diagnostic Testing*         Outpatient Hospital or Office Based Laboratory Services:         Deductible then \$40 Copayment           Deductible or Office Based Laboratory Services:         Deductible then \$40 Copayment         Deductible then \$40 Copayment           Outpatient Hospital or Office Based Laboratory Services:         Deductible then \$40 Copayment         Deductible then \$40 Copayment           Prescription Drugs Administered in Office or Outpatient Facilities*         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           Specialist Office         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           Outpatient Facility         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           With Hamit MathinStubians Use Inpaient Services         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           Coloratient Realt Descinces         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           With Hamit MathinStubians Use Inpaient Services         Deductible then \$20% Coinsurance         Deductible then \$20% Coinsurance           Courter In Hall Hamit Nubustance Use Office-Based Services         Deductible then \$20% Coinsurance         Deductible then \$40 Copayment<	Ambulance	Deductible then \$100 Copayment
Diagnostic Tasting* Outgatent Hespital or Office Based Laboratory Services: Deductible then S40 Copayment Deductible Based Radiology Services: Deductible Based Radiology Services: Deductible Inten S40 Copayment Prescription Drugs Administered in Office or Outpatient Facilities* PCP Office Deductible Inten 20% Coinsurance Deductible Inten 20% Coinsurance The cost share applies to the drug only, there is no separate cost share for the administration of the drug Bahavioral Health Services Deductible Inten 5800 Copayment Mental Health/Subtance Use Office-Based Services Deductible Inten 5800 Copayment Mental Health/Subtance Use Internet Services Deductible Inten 5800 Copayment Mental Health/Subtance Use Office-Based Services Deductible Inten 5800 Copayment Mental Health Care (40 visits per Coinsurance) for OT. PT, ST) Condition Support Services Deductible Inten 580 Copayment Heater (20 visits per coinselvices (PT) ysical Therapy, Occupational Therapy or Speech Therapy) Deductible Inten 580 Copayment Deductible Inten 582 Copayment Deductible Inten 580 Coinsur	Urgent Care	
Outpatient Hospital or Office Based Laboratory Services:         Deductible Operations         Deductible Inter \$40 Copayment           Organient Maxied I provider is a prefered conter.         Deductible Inter \$20% Coinsurance         Deductible Inter \$20% Coinsurance           OUtpatient Facility         Deductible Inter \$20% Coinsurance         Deductible Inter \$20% Coinsurance           Outpatient Facility         Deductible Inter \$20% Coinsurance         Deductible Inter \$20% Coinsurance           Mental Health/Substance Use Inpatient Services         Deductible Inter \$20% Coinsurance           Mental Health/Substance Use Inpatient Services         Deductible Inter \$20% Coinsurance           Outpatient Rehabilitation Kenter         Deductible Inter \$20% Coinsurance           Outpatient Rehabilitation Networks         Deductible Inter \$40 Copayment           Outpatient Rehabilitation Rehabilitation Reprint pare to coinse directory.         Coursed Intel \$40 Copayment           Outpatient Rehabilitation Networks         Deductible Inter \$40 Copayment           Skilled Nursing Facility (365 days per plan year)         Deductible Inter \$40 Copayment           Coereerd In full         Science         Science         Science           Outpatient Rehabilitat	When seeking care within CDPHP's Service Area, a participating Urgent Care Center must be used.	Deductible then \$60 Copayment
<ul> <li>Deductible Copayment waived if provider is a preferred laboratory.</li> <li>Deductible then S40 Copayment</li> <li>Coupayment waived if provider is a preferred center.</li> <li>Prescription Drugs Administered in Office or Outpatient Facilities*</li> <li>COP Office</li> <li>Deductible then 20% Coinsurance</li> <li>Outpatient Anguing State of Consurance</li> <li>Deductible then 20% Coinsurance</li> <li>The cost share applies to the drug only, there is no separate cost share for the administration of the drug</li> <li>Behavioral Health Services</li> <li>Deductible then \$300 Copayment</li> <li>Mental Health/Subtance Use Inpatient Services</li> <li>Deductible then \$300 Copayment</li> <li>Tube to share applies to the drug only, there is no separate cost share for the administration of the drug</li> <li>Tube to share applies to the drug only, there is no separate cost share for the administration of the drug</li> <li>Behavioral Health/Subtance Use Inpatient Services</li> <li>Deductible then \$300 Copayment</li> <li>Tube to 20 visits per plan year may be used for substance use family counseling.)</li> <li>Condition Support Services</li> <li>Outpatient feabulation (Habitiston Services (Physical Therapy, Occupational Therapy or Speech Therapy)</li> <li>Deductible then \$300 Copayment</li> <li>Tube Health Care (40 visits per plan year combined Hearpies for OT, PT, ST)</li> <li>Home Health Care (40 visits per plan year)</li> <li>Deductible then \$300 Copayment</li> <li>Cherotherapy/Reliation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost</li> <li>State Oraring Facility (Se6 days per plan year)</li> <li>Deductible then \$300 Copayment</li> <li>Deductible then \$300 Copayment</li> <li>Cherotherapy</li></ul>	Diagnostic Testing*	
* Colgament waived if provider is a preferred center. Deductible their S40 Uopkyriteitt Prescription Drugs Administered in Office or Outpatient Facilities* PCP Office Deductible then 20% Coinsurance Specialite Office Deductible then 20% Coinsurance Dutpatient Facility Deductible then 20% Coinsurance Colgatient Facility Deductible then 20% Coinsurance Metal Health/Substance Use Inpatient Services Deductible then S00 Copayment Metal Health/Substance Use Inpatient Services Metal Health/Substance Use Inpatient Services Deductible then S00 Copayment (Up to 20 visits per plan year may be used for substance use family counseling.) Condition Support Services Outpatient fachaltistics Condition Support Services Outpatient fachaltistics Covered in full Conductible then S00 Copayment Covered in full Covered in full Covered in full Conductible then S00 Copayment Covered in full Conductible then S00 Copayment Covered in full Conductible then S00 Copayment Covered in full Covered in full Covered in full Conductible then S00 Copayment Covered in full Comotherapy/Rediation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost Prosthetic Devices and Durable Medical Equipment Covered in full Covered in f	Outpatient Hospital or Office Based Laboratory Services: * Deductible/Copayment waived if provider is a preferred laboratory.	Deductible then \$40 Copayment
PCP Office       Deductible then 20% Coinsurance         Specialist Office       Deductible then 20% Coinsurance         Outpatient Facility       Deductible then 20% Coinsurance         The cost share applies to the drug only, there is no separate cost share for the administration of the drug       Deductible then 20% Coinsurance         Behavioral Health Services       Deductible then \$800 Copayment         Mental Health/Substance Use Inpatient Services       Deductible then \$20% Coinsurance         Condition Support Services       Deductible then \$20% Coinsurance         Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)       Deductible then \$40 Copayment         Condition Support Services       Deductible then \$400 Copayment       Covered in full         Skilled Nursing Facility (365 days per plan year)       Deductible then \$50% Coinsurance         Skilled Nursing Facility (365 days per plan year)       Deductible then \$20% Coinsurance         ChemotherapyReadation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost       Deductible then \$20% Coinsurance         Diabetic Services       Sago or \$690 Copayment Through Hearing Care       Solutions         Diabetic Services       Solutions       Solutions         Diabetic Services       Deductible then \$40 Copayment       Coverage is for standard lenses and frames or contact lenses and frames or contact lenses (Consuranc	Outpatient Hospital or Office Based Radiology Services: * Copayment waived if provider is a preferred center.	Deductible then \$40 Copayment
Specialist Office         Deductible then 20% Coinsurance           Outpatient Facility         Deductible then 20% Coinsurance           Whe cast share applies to the drug only, there is no separate cost share for the administration of the drug         Deductible then 20% Coinsurance           Behavioral Health Soutsance Use Inpatient Services         Deductible then \$800 Copayment           Mental Health/Substance Use Office-Based Services         Deductible then \$20% Coinsurance           Condition Support Services         Deductible then \$400 Copayment           Condition Support Services         Deductible then \$400 Copayment           Mental Health/Substance Use Office-Based Services (Physical Therapy, Occupational Therapy of Speech Therapy)         Deductible then \$400 Copayment           (90 visits per ondition per jain year combined therapies for OT, PT, ST)         Deductible then \$20% Coinsurance           Skilled Nursing Facility (365 days per plan year)         Deductible then \$20% Copayment           Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost solutions and Durable Medicial Equipment         Solutions           Prosthetic Devices and Durable Medical Equipment         Solutions         Solutions           Includes Insulin is limited to \$100 out of pocket per 30 day supply, Glucometers and Diabetic Stropayment         Solutions           DMEL Includes Insulin of amedication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic Stropayment	Prescription Drugs Administered in Office or Outpatient Facilities*	
Outpatient Facility         Deductible then 20% Coinsurance           Whe cest share applies to the drug only, there is no separate cost share for the administration of the drug         Mental Health/Services           Behavioral Health Services         Deductible then \$800 Copayment           Mental Health/Substance Use office-Based Services         Deductible then \$25 Copayment           (Up to 20 visits per plan year may be used for substance use family counseling.)         Covered in full           Condition Support Services         Deductible then \$20 Copayment           Uptation Rehabilitation Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)         Deductible then \$40 Copayment           Kölles Mursing Facility (365 days per plan year)         Deductible then \$20 Copayment           Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)         Deductible then \$20 Copayment           Prosthetic Devices and Durable Medical Equipment         Deductible then \$20 Copayment           Diabetic Services         Stare of then \$20 Copayment           OMLine Adult Vision Exam (One exam per plan year)         Deductible then \$40 Copayment           Vision Services         Coverence is or standard lenses and frames or contac lenses, up to a \$75 reimbursement and therapes or contac lenses (On exam per plan year)         Deductible then \$40 Copayment           Vision Exam (One exam per plan year)         Deductible then \$50 Copayment	PCP Office	Deductible then 20% Coinsurance
The cost share applies to the drug only, there is no separate cost share for the administration of the drug Behavioral Health Services Deductible then \$200 Copayment Mental Health/Substance Use Inpatient Services Deductible then \$250 Copayment ("Up to 20 visits per plan year may be used for substance use family counseling.) Condition Support Services Outpatient Rehabilitation/Habilitation Services ('Physical Therapy, Occupational Therapy or Speech Therapy) (Bo visits per condition per plan year combined therapies for OT, PT, ST) Deductible then \$400 Copayment ("Bo visits per condition per plan year combined therapies for OT, PT, ST) Deductible then \$400 Copayment Condition support services Condition per plan year combined therapies for OT, PT, ST) Deductible then \$400 Copayment Condition ber plan year combined therapies for OT, PT, ST) Deductible then \$400 Copayment Condition per plan year combined therapies for OT, PT, ST) Deductible then \$400 Copayment Conductible then \$400 Copayment Conductible then \$400 Copayment Conductible then \$400 Copayment Conductible then \$400 Copayment Deductible then \$400 Copayment Conductible then \$400 Copayment Deductible then \$400 Copayment Deductible then \$400 Copayment Deductible then \$400 Copayment States St	Specialist Office	Deductible then 20% Coinsurance
Behavioral Health Services         Deductible then \$800 Copayment           Mental Health/Substance Use Inflace-Based Services         Deductible then \$25 Copayment           //Up to 20 visits per plan year may be used for substance use family counseling.)         Condition support Services           Condition Support Services         Outpatient Rehabilitation Mervices (Physical Therapy Occupational Therapy or Speech Therapy)         Deductible then \$40 Copayment           (if 00 visits per onolition per jan year combined therapies for OT, PT, ST)         Deductible then \$40 Copayment           Killed Mursing Facility (365 days per plan year)         Covered in full           Skilled Mursing Facility (365 days per plan year)         Deductible then \$25 Copayment           Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost         Deductible then \$25 Copayment           Prosthetic Devices and Durable Medical Equipment         Deductible then \$300 Copayment through Hearing Care Solutions           Diabetic Services         Sile of Name Strong	Outpatient Facility	Deductible then 20% Coinsurance
Mental Health/Substance Use Inpatient Services         Deductible then \$800 Copayment           Mental Health/Substance Use Office-Based Services         Deductible then \$25 Copayment           Condition Support Services         Deductible then \$40 Copayment           Outpatient Rehabilitation Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)         Deductible then \$40 Copayment           Yillo to Sing Facility (365 days per plan year)         Deductible then \$800 Copayment           Skilled Mursing Facility (365 days per plan year)         Deductible then \$25 Copayment           Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)         Deductible then \$20 Copayment           Posthetic Devices and Durable Medical Equipment         Deductible then \$0% Coinsurance         Solutions           Note: Insulin or all medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic         \$25 Copayment           Diabetic Services         Solutions         Solutions           Deductible then \$40 Copayment         Solutions         Solutions           Mental Health (Vision Exam (One exam per plan year)         Deductible then \$40 Copayment         Solutions           Vision Services         Solutions         Solutions         Solutions           Routine Pediatric Vision Exam (One exam per plan year)         Deductible then \$40 Copayment           Coverage	*the cost share applies to the drug only, there is no separate cost share for the administration of the drug	
Mental Health/Substance Use Office-Based Services     Deductible then \$25 Copayment       '(Up to 20 visits per plan year may be used for substance use family counseling.)     Condition Support Services       Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)     Deductible then \$40 Copayment       (E0 visits per plan year combined therapies for OT, PT, ST)     Deductible then \$40 Copayment       Home Health Care (40 visits per plan year)     Covered in full       Skilled Nursing Facility (365 days per plan year)     Deductible then \$25 Copayment       Chemotherapy Relation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)     Deductible then 50% Coinsurance       Prostheit Devices and Durable Medical Equipment     Deductible then 50% Coinsurance       Hearing Aids     \$25 Copayment through Hearing Care Solutions       Diabetic Services     Selve proces       Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic Stor Socs     \$25 Copayment       Outie Adult Vision Exam (One exam per plan year)     Deductible then \$40 Copayment       Adult Giasses/Contacts     Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement for eligible eye surgeries and consultations per lifetime       Routine Adult Vision Exam (One exam per plan year)     Deductible then \$25 Copayment       Pediatric Giasses/Contacts     Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement or	Behavioral Health Services	
(Up to 20 visits per plan year may be used for substance use family counseling.)         Condition Support Services         Outpatient Rehabilitation Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)       Deductible then \$40 Copayment         (100 visits per condition of plan year)       Covered in full         Skilled Nursing Facility (365 days per plan year)       Deductible then \$200 Copayment         Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)       Deductible then \$25 Copayment         Prosthetic Devices and Durable Medical Equipment       Deductible then \$300 Copayment through Hearing Care Solutions         Diabetic Services       Saley or \$699 Copayment through Hearing Care Solutions         Includes Insultin is limited to \$100 out of pocket per 30 day supply. Glucometers and Diabetic Services       \$25 Copayment         Niculae Services       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement Routine Patiantic Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Vision Services       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement for eligible cybe surgery       Up to a \$75 reimbursement for eligible cybe surgery         Vision Exam (One exam per plan year)       Deductible then 50% Coinsurance lenses and frames or contact lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance lenses and frames or contact lenses act for embursed up to a \$750 reim	Mental Health/Substance Use Inpatient Services	Deductible then \$800 Copayment
Condition Support Services         Outpatient Rehabilitation Y Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)       Deductible then \$40 Copayment         Y60 visits per condition per plan year combined therapies for OT, PT, ST)       Deductible then \$40 Copayment         Nom Health Care (40 visits per plan year)       Covered in full         Skilled Nursing Facility (365 days per plan year)       Deductible then \$25 Copayment         Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)       Deductible then \$25 Copayment         Prosthetic Devices and Durable Medical Equipment       Deductible then \$25 Copayment through Hearing Care Solutions         Diabetic Services       Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to \$100 out of pocket per 30 day supply.       Silon Services         Routine Adult Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement         Vision Services       Up to a \$100 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement for eligible eyes surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement of wearable fitness Reimbursement         Weight Management       Up to a	Mental Health/Substance Use Office-Based Services	Deductible then \$25 Copayment
Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)         Deductible then \$40 Copayment           (60 visits per condition per plan year combined therapies for OT, PT, ST)         Deductible then \$40 Copayment           Skilled Nursing Facility (365 days per plan year)         Deductible then \$20 Copayment           Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)         Deductible then \$25 Copayment           Prosthetic Devices and Durable Medical Equipment         Deductible then \$25 Copayment through Hearing Care Solutons           Diabetic Services         Sign of \$699 Copayment through Hearing Care Solutons           Diabetic Services         Sign of \$25 Copayment           Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to \$100 out of pocket per 30 day supply.         Deductible then \$40 Copayment           Vision Services         Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement           Routine Adult Vision Exam (One exam per plan year)         Deductible then \$25 Copayment           Vision Services         Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement           Routine Pediatric Vision Exam (One exam per plan year)         Deductible then \$25 Copayment           Pediatric Glasses/Contacts         Coverage is for standard lenses and frames per plan year. Standard Frames) <td>*(Up to 20 visits per plan year may be used for substance use family counseling.)</td> <td></td>	*(Up to 20 visits per plan year may be used for substance use family counseling.)	
r(60 visits per condition per plan year combined therapies for OT, PT, ST)       Visits the condition per plan year combined therapies for OT, PT, ST)       Visits the condition per plan year combined therapies for OT, PT, ST)         Home Health Care (40 visits per plan year)       Deductible then \$800 Copayment         Skilled Nursing Facility (365 days per plan year)       Deductible then \$25 Copayment         DenemberapyRadiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)       Deductible then \$25 Copayment         Prosthetic Devices and Durable Medical Equipment       Deductible then \$00 Coinsurance         Hearing Aids       \$399 or \$699 Copayment through Hearing Care Solutions         Dilabetic Services       Solutions         Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic \$25 Copayment       \$25 Copayment         Weight Madult Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Adult Glasses/Contacts       Coverage is for standard Ineses and frames or contact lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$0% Coinsurance         Pediatric Glasses/Contacts       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to \$100 reimbursement for eligible eyes consultations per lifetime         Weight Management       Subscribers can be erp	Condition Support Services	
Skilled Nursing Facility (365 days per plan year)       Deductible then \$800 Copayment         Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)       Deductible then \$25 Copayment         Prosthetic Devices and Durable Medical Equipment       Deductible then \$0% Coinsurance         Hearing Aids       \$399 or \$699 Copayment through Hearing Care Solutions         Diabetic Services       Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to \$100 out of pocket per 30 day supply.       Solutions         Vision Services       Example of the \$400 Copayment         Routine Adult Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then \$25 Copayment         Velatine S Care       Up to a \$100 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement of wearable fittees devices. Covered dependents can be reimbursed up to 3 combined \$200 for reimbursement of wearable fittees devices. Covered dependents can be reimbursed up to a combined \$200 for or envarbursed up to \$200 can be applied for reimbursement of wearable fittes devices. <td>Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *(60 visits per condition per plan year combined therapies for OT, PT, ST)</td> <td>Deductible then \$40 Copayment</td>	Outpatient Rehabilitation/ Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *(60 visits per condition per plan year combined therapies for OT, PT, ST)	Deductible then \$40 Copayment
Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)         Deductible then \$25 Copayment trough Prescription Drugs Administered in Office for Drug cost between the state of t	Home Health Care (40 visits per plan year)	Covered in full
share) the the formation of the formatio	Skilled Nursing Facility (365 days per plan year)	Deductible then \$800 Copayment
Hearing Aids       \$399 or \$699 Copayment through Hearing Care Solutions         Diabetic Services       Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic       \$25 Copayment         DME. Insulin is limited to \$100 out of pocket per 30 day supply.       Deductible then \$40 Copayment         Vision Services       Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement         Routine Adult Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contac lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participator in a weight loss program         Fitness Reimbursement       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities, of the \$400, up to \$200 can be applied for reimbursement wearable fitness devices. Covered dependents can be reimbursed up to a combine \$200 for qualified fitness activities and youth sports \$200 for qualified fitness activities and youth sports \$200 for an be applied for reimbursement of wearable fitness devices.         Colid Bitthing Clas	Chemotherapy/Radiation Therapy visit (See also Prescription Drugs Administered in Office for Drug cost share)	Deductible then \$25 Copayment
Inearing Auds       Solutions         Diabetic Services       Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic       \$25 Copayment         DME. Insulin is limited to \$100 out of pocket per 30 day supply.       Deductible then \$40 Copayment         Vision Services       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Routine Adult Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$26 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participator in a weight loss program         Fitness Reimbursement       Subscribers can be applied for reimbursement of wearable fitness devices. Covered dependents can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Fitness Reimbursement       Up to \$75 reimbursement of wearable fitness devices.         Covi	Prosthetic Devices and Durable Medical Equipment	Deductible then 50% Coinsurance
Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to \$100 out of pocket per 30 day supply. Vision Services Routine Adult Vision Exam (One exam per plan year) Adult Glasses/Contacts Routine Pediatric Vision Exam (One exam per plan year) Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames) Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames) Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames) Laser Eye Surgery Weight Management Weight Management Fitness Reimbursement Fitness Reimbursement Fitness Reimbursement Columna Classes (Contacts Core dependents can be reimbursed up to a \$100 reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to 300 or an be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to \$100 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to \$100 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to \$100 can be applied for reimbursement available for completion of the \$200 can be applied for an be applied for reimbursed up to \$100 can be applied for reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.	Hearing Aids	
DME. Insulin is limited to \$100 out of pocket per 30 day supply.       \$25 Copayment         Vision Services       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participatior in a weight loss program         Fitness Reimbursement       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ago 18. Of the \$200, u	Diabetic Services	
Routine Adult Vision Exam (One exam per plan year)       Deductible then \$40 Copayment         Adult Glasses/Contacts       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participatior in a weight loss program         Fitness Reimbursement       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable for sembursement of wearable fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable for completion of reimbursement of wearable fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimburseme	Includes Insulin, oral medication, needles and syringes - up to a 30 day supply, Glucometers and Diabetic DME. Insulin is limited to \$100 out of pocket per 30 day supply.	\$25 Copayment
Adult Glasses/Contacts       Coverage is for standard lenses and frames or contact lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participation in a weight loss program         Fitness Reimbursement       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of the set and the	Vision Services	
Adult Glasses/Contacts       lenses, up to a \$75 reimbursement         Routine Pediatric Vision Exam (One exam per plan year)       Deductible then \$25 Copayment         Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Wellness Care       Up to a \$100 reimbursement available for participation in a weight loss program         Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Bitthing Classes       Up to \$75 reimbursement available for completion of	Routine Adult Vision Exam (One exam per plan year)	Deductible then \$40 Copayment
Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)       Deductible then 50% Coinsurance         Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Wellness Care       Up to a \$100 reimbursement available for participation in a weight loss program         Weight Management       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for members under age 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of	Adult Glasses/Contacts	
Laser Eye Surgery       Up to a maximum of \$750 reimbursement for eligible eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participation in a weight loss program         Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under age 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of	Routine Pediatric Vision Exam (One exam per plan year)	Deductible then \$25 Copayment
Laser Eye Surgery       eye surgeries and consultations per lifetime         Weight Management       Up to a \$100 reimbursement available for participation in a weight loss program         Weight Management       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of	Pediatric Glasses/Contacts (One prescribed lenses and frames per plan year. Standard Frames)	Deductible then 50% Coinsurance
Weight Management       Up to a \$100 reimbursement available for participation in a weight loss program         Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of	Laser Eye Surgery	
weight Management       in a weight loss program         in a weight loss program       Subscribers can be reimbursed up to \$400 per plan year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices.         Child Birthing Classes       Up to \$75 reimbursement available for completion of	Wellness Care	
Fitness Reimbursement Fitness Reimbursement fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for reimbursement of wearable fitness devices. Child Birthing Classes Up to \$75 reimbursement available for completion of	Weight Management	Up to a \$100 reimbursement available for participation in a weight loss program
Unito Bitatino Classes	Fitness Reimbursement	year for qualified fitness activities. Of the \$400, up to \$200 can be applied for reimbursement of wearable fitness devices. Covered dependents can be reimbursed up to a combined \$200 for qualified fitness activities and youth sports fees for members under ag 18. Of the \$200, up to \$100 can be applied for
	Child Birthing Classes	Up to \$75 reimbursement available for completion of child birthing class

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

Marketing Plan ID: 220Plan Code:SUGF3416Group ID:PROSPECTPresented For:PROSPECTDate Prepared:Effective Date:Effective Date:20240101Metal Tier:GOLD



	In-Network
Doula Reimbursement (A doula is a trained companion who supports another person through pregnancy and childbirth)	\$1,500
Life Points Rewards	Participating (Up to \$180 Life Points per contract per calendar year)
Acupuncture (10 visit limit per plan year for acupuncture services)	Deductible then \$40 Copayment
Nutritional Counseling	Deductible then \$40 Copayment
Chiropractic Benefits	Deductible then \$40 Copayment

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.

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.

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.