CDPHN : Pipefitters Welfare Fund Local 773

Coverage for: All Tiers | **Plan Type: EPO High**

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. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.cdphp.com** or by calling (518) 641-3100 or 1-877-724-2579.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $750 individual $1,875 family	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?	**Deductible** does not apply to **preventive care**, certain diabetic services, and **prescription drugs.**	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 Medical: $2,000 individual/$5,000 family In-Network Rx charges: $4,850 individual/ $8,700 family	The **out-of-pocket-limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	**Premiums, balance billed** 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 1-877-269-2134 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). 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
		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	$35 co-pay	Not Covered	Hospital clinics are not covered.
	Specialist visit	$35 co-pay	Not Covered	Hospital clinics are not covered.
	Preventive care/screening/ immunization	No Charge	Not Covered	Hospital clinics are not covered.
If you have a test	Diagnostic test (x-ray, blood work)	Ded. then $35 co-pay	Not Covered	Covered in full when part of a preventive office visit.
	Imaging (CT/PET scans, MRIs)	Ded. then $35 co-pay	Not Covered	Precertification is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.expressscripts.com	Generic drugs	Retail: $5 co-pay Mail-Order: $10 co-pay	Not Covered	Covers up to a 30-day supply (retail prescription); 13-90 day supply (mail order prescription) Maintenance Drugs must be filled via mail order and will be subject to 2 copays for a 3 month supply. Must use generic if available unless RX is dispensed as written. Prescription Drug Coverage is not administered by CDPHP; please contact Express Scripts 1-866-544-2930
	Preferred brand drugs	Retail: 20% coin Mail-Order: 20% coin	Not Covered	
	Non-preferred brand drugs	Retail: 20% coin Mail-Order: 20% coin	Not Covered	
	Specialty drugs	Retail: 20% coin Mail-Order: 20% coin	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ded. then $35 co-pay	Not Covered	Precertification is required.
	Physician/surgeon fees	Ded. then $35 co-pay	Not Covered	Precertification is required.
If you need immediate medical attention	Emergency room care	$200 co-pay	$200 co-pay	All Emergency Care is considered In-Network. Copayment waived if admitted within 24 hours.
	Emergency medical transportation	Ded. then $35 co-pay	Ded. then $35 co-pay	All Emergency Care is considered In-Network.
	Urgent care	$35 co-pay	$50 co-pay	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	Ded. then $35 co-pay	Not Covered	Precertification is required.
	Physician/surgeon fees	Ded. then $35 co-pay	Not Covered	Precertification is required.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$35 co-pay	Not Covered	*See SPD for limitations on these services
	Inpatient services	Ded. then $35 co-pay	Not Covered	Precertification is required.
If you are pregnant	Office visits	Ded. then $35 co-pay	Not Covered	None.
	Childbirth/delivery professional services	Ded. then $35 co-pay	Not Covered	None.
	Childbirth/delivery facility services	Ded. then $35 co-pay	Not Covered	None.
If you need help recovering or have other special health needs	Home health care	$35 co-pay	Not Covered	Precertification is required. Services are limited to 100 visits per plan year.
	Rehabilitation services	Ded. then $35 co-pay	Not Covered	The Office Visit Copayment applies to office visits, examinations and evaluations. All other Covered Services rendered during visit are subject to cost share. Precertification is required.
	Habilitation services	Ded. then $35 co-pay	Not Covered	Occupational, Speech, and Vision Therapy are limited to 30 visits per plan year combined. Physical Therapy is limited to 30 visits per plan year. Precertification is required.
	Skilled nursing care	Ded. then $35 co-pay	Not Covered	Limited to 60 days per plan year. Precertification is required.
	Durable medical equipment	Ded. then $35 co-pay	Not Covered	Prior authorization required for items in excess of $500
	Hospice services	Ded. then $35 co-pay	Not Covered	None.
Dental or Eye Care	Eye exam	$0 co-pay	Not Covered	Once every 24 months for adults. Once every 12 months for dependents under 19.
	Glasses or Contacts	$250 Allowance		Once every 24 months for adults. Once every 12 months for dependents under 19.
	Dental check-up	Not Covered	Not Covered	Carved out to Delta Dental

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	$750
Specialist	$35
Hospital (facility)	Ded. Then $35
Other	N/A

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,310**

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

The plan's overall deductible	$750
Specialist	$35
Hospital (facility)	Ded. Then $35
Other	N/A

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	$750
Copayments	$600
Coinsurance	$600
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,970**

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

The plan's overall deductible	$750
Specialist	$35
Hospital (facility)	Ded. Then $35
Other	N/A

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	$750
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,450**

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

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
- Long term care
- 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 (Limits Apply)
- Bariatric surgery (Limits Apply)
- Chiropractic care
- Infertility treatment (see SPD for details)

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.govOther 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
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 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.