CDPHP® HMO Plan Benefit Summary

Plan Code: HM2L26
Group ID: 10005140
Presented For: Manatt Phelps & Phillips, LLP
Date Prepared: 8/8/2026
Effective Date: 12/01/2026

	In-Network
Cost Sharing Information	
Deductible	N/A Single / N/A Family
Out of Pocket Maximum	$10,150 Single / $20,300 Family (Embedded)
Office Visits	
PCP	$30 Copayment
*PCP Cost share waived for members that are under the age of 19	
Specialist	$50 Copayment
Telemedicine	
Preferred Live Video Doctor Visits (Doctor on Demand, Foodsmart, MovN)	Covered in Full
Other Participating Telemedicine Providers (Valera, aptihealth)	$30 Copayment
Telehealth services from a CDPHP Network provider (PCP or Specialist)	PCP or Specialist cost share based on provider
Preventive and Well Care Services*	
Well 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	
Hospital Services	
Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab tests, etc)	$1,000 Copayment
Outpatient Surgery Facility * Cost share may be reduced at a preferred ambulatory surgery center.	$150 Copayment
Maternity Services*	
Maternity - Routine Prenatal Care and Postnatal Care	Covered in Full*
Maternity - Inpatient Hospital Services	$1,000 Copayment
Newborn Nursery	Covered in full
*(Non-routine services may result in an additional cost share)	
Emergency Care	
Worldwide Emergency Room Care (waived if admitted inpatient)	$100 Copayment
Ambulance	$100 Copayment
Urgent Care	
When seeking care within CDPHP's Service Area, a participating Urgent Care Center must be used.	$35 Copayment
Diagnostic Testing*	
Outpatient Hospital or Office Based Laboratory Services: * Copayment waived if provider is a preferred laboratory.	$50 Copayment
Outpatient Hospital or Office Based Radiology and Imaging Services (X-ray, Ultrasound): * Copayment waived if provider is a preferred center.	$50 Copayment
Outpatient Hospital or Office Based Advanced Imaging Services (MRI, CT Scan, PET Scan):	$150 Copayment
Behavioral Health Services	
Mental Health/Substance Use Inpatient Services	$1,000 Copayment
Mental Health/Substance Use Office-Based Services (Including Telemedicine Providers (Valera, aptihealth))	$30 Copayment
*(Up to 20 visits per plan year may be used for substance use family counseling.)	
Outpatient Rehabilitation Services	

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Physical Therapy	$50 Copayment (30 visits per benefit period)
Speech Therapy	$50 Copayment (20 visits per benefit period)
Occupational Therapy	$50 Copayment (30 visits per benefit period)
Condition Support Services	
Home Health Care	Covered in full
Skilled Nursing Facility	$1,000 Copayment (45 days per plan year)
Chemotherapy/Radiation Therapy visit	$30 Copayment
Prosthetic Devices and Durable Medical Equipment	20% Coinsurance
Diabetic Services	
Insulin	Covered in full
Oral Medications	$30 Copayment
Needles and Syringes	$30 Copayment
Diabetic DME (Insulin Pumps/Omni Pods, Glucose Monitors)	$30 Copayment
Vision Services	
Laser Eye Surgery	Up to a maximum of $750 reimbursement for eligible eye surgeries and consultations per lifetime
Wellness Care	
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 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 child birthing class
Doula Reimbursement (A doula is a trained companion who supports another person through pregnancy and childbirth)	$1,500
Life Points Rewards	Available
Acupuncture (10 visit limit per plan year for acupuncture services)	$50 Copayment
Nutritional Counseling	$50 Copayment
Chiropractic Benefits	$50 Copayment

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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 gives you access to more than 12,000 participating practitioners and providers, including most of the local 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.

Some plans may have reduced cost-share for office-based mental health and substance use disorder services to ensure the plan meets federal behavioral health parity regulations. Please refer to the Mental Health/Substance Use Office-Based Services section of the summary and your member materials for correct cost-share information.

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Your employer has chosen the following rider(s) to modify the Plan under which you would be covered as a CDPHP Member.

DME Riders	
Rider Name	DME2
Description	Durable medical equipment, prosthetics, orthotics, and oxygen are covered at 20% coinsurance in-network. There is no coverage for orthotic shoe inserts.
Domestic Partnership	
Rider Name	ELG12
Description	Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children.
Pharmacy Coverage	
Rider Name	HMRXL4A26
Description	Preferred Retail Prescription Drugs (30 Day Supply) Tier 1 Drugs* $10 Tier 2 Drugs $30 Tier 3 Drugs $50 Non-Preferred Retail Pharmacy (30 Day Supply) Tier 1 Drugs 50% Tier 2 Drugs 50% Tier 3 Drugs 50% Specialty Drugs $50 *Copay/Coinsurance waived for members under age 19 Mail order, 2.0 Preferred Tier Copayments for a 90-day supply. Prescription drugs are not subject to the plan deductible. Preventive prescription drugs are not subject to the plan deductible. 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.
Vision Coverage	
Rider Name	VSN2
Description	One routine eye exam is available every 24 months, commencing on the group effective date, without referral, refer to specialist office visit for cost share.