

2008 Chamber High Deductible PPO Benefit Summary

(HSA Qualified Plan)	In-Network	Out-of-Network
Annual Deductible (All services are subject to the deductible including those covered under any additional riders, except as otherwise noted. The family deductible must be met in full by any combination of family members before any benefits will be paid)	\$2,700 single, \$5,400 family	\$5,000 single, \$10,000 family
Coinsurance	10% (See also DME below)	50%
Annual Out-of-Pocket Maximum	\$4,000 single, \$8,000 family	\$10,000 single, \$20,000 family
Annual Benefit Maximum – combined total of all in and out of network services		\$1,000,000
Pre-Existing Condition Waiting Period – not applicable to pregnancy or newborns		Pre-existing condition waiting period applies
Services	Your Out-of-Pocket Responsibility	
Physician Services		
Office visits for illness or injury, or second opinion	Deductible then 10%	Deductible then 50%
Well-baby and well-child care including immunizations/inoculations	Covered in full (<i>not subject to the deductible</i>)	Deductible then 50%
Annual adult exam	Covered in full (<i>not subject to the deductible</i>)	Deductible then 50%
Annual gynecological exam	Covered in full (<i>not subject to the deductible</i>)	Deductible then 50%
Hospital Services		
Inpatient hospital (semi-private room, anesthesia, X-ray, lab tests, etc.)	Deductible then 10%	Deductible then 50%
Outpatient surgery	Deductible then 10%	Deductible then 50%
Diagnostic Testing		
Laboratory services	Deductible then 10% (<i>coinsurance waived when a designated laboratory provider is used</i>)	Deductible then 50%
Radiology and imaging (X-rays, ultrasounds, CT scans, etc.)	Deductible then 10% (<i>coinsurance waived at designated sites</i>)	Deductible then 50%
Mammogram (<i>not subject to the deductible</i>)	Covered in full	Deductible then 50%
Cytology screening (<i>not subject to the deductible</i>)	Covered in full	Deductible then 50%
Prostate cancer screening (<i>not subject to the deductible</i>)	Covered in full	Deductible then 50%
Maternity		
Physician services	Deductible then 10%	Deductible then 50%
Inpatient hospital services	Deductible then 10%	Deductible then 50%
Newborn nursery	Deductible then covered in full	Deductible then 50%
Emergency Care		
Worldwide emergency room care	Deductible then 10%	All emergency care is considered in-network.
Ambulance	Deductible then 10%	
Urgent Care – nonparticipating Urgent Care facility services within the CDPHP UBI service area are not covered	Deductible then 10%	Deductible then 50%

Your Out-of-Pocket Responsibility

Services	In-Network	Out-of-Network
Physical Therapy – limit 30 visits per benefit period in- and out-of-network combined	Deductible then 10%	Deductible then 50%
Speech Therapy	Not covered	Not covered
Occupational Therapy – limit 30 visits per benefit period in- and out-of-network combined	Deductible then 10%	Deductible then 50%
Chiropractic Benefits	Deductible then 10%	Deductible then 50%
Home Health Care	Deductible then 10%	Deductible then 50%
Skilled Nursing Facility	Not covered	Deductible then 50%
Prosthetic Devices and Durable Medical Equipment (DME)	Deductible then 50% coinsurance <i>Limited to \$25,000 per lifetime</i>	Covered in-network only
Diabetic Care		
Insulin and oral medications – Up to a 30-day supply	Deductible then \$15	Deductible then 50%
Diabetic supplies (needles, syringes, etc.) – Up to a 30-day supply	Deductible then \$15	Deductible then 50%
Glucometers	Deductible then \$15	Deductible then 50%
Diabetic DME	Deductible then \$15	Deductible then 50%
Mental Health Services		
Outpatient mental health services – up to 20 visits per benefit period	Deductible then 10%	Deductible then 50%
Inpatient mental health services – up to 30 days per benefit period	Deductible then 10%	Deductible then 50%
<i>Biologically based mental illness and coverage for children with serious emotional disturbance is available beyond those limits for outpatient and inpatient services</i>		
Chemical Abuse and Dependency		
Outpatient services – Up to 60 visits per calendar year	Deductible then 10%	Deductible then 50%
Inpatient detoxification – Up to 7 days per benefit period	Not covered	Not covered
Inpatient rehabilitation – Up to 30 visits per benefit period	Not covered	Not covered

Dependent Coverage

Up to age 19

This HDPPPO Plan is underwritten by CDPHP Universal Benefits, Inc. (CDPHP UBI). CDPHP UBI gives you access to a wide range of physicians, specialists, and hospitals in addition to the option to access physicians and providers outside the network. You also have access to a variety of value-added services to help you and your family stay healthy. If you have a question about CDPHP UBI, please contact the marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

You must comply with the CDPHP UBI managed benefits program as set forth in the contract to receive the maximum benefits for all services. Failure to do so will result in your being responsible for an additional payment of 50 percent of the allowed amount up to a maximum of \$500 for each service otherwise payable, in addition to the applicable copayments, deductible, and/or coinsurance.

All benefits of this Plan are subject to coordination of benefits. This summary is designed to highlight the benefits of the plan being offered and does not detail all benefits, limitations, or exclusions. It is not a contract and may be subject to change. For more detailed information, a membership certificate is available for your review upon request. The insurance evidenced by this benefit summary meets the minimum standards for basic hospital and basic medical insurance as defined by the New York State Department of Insurance. It does not provide major medical insurance.