

CDPHP TRI-STATE CHAMBER OF COMMERCE
ENROLLMENT PROCEDURES

1. Complete the appropriate Chamber application with a check to Tri-State Chamber Of Commerce for membership (\$185).
2. Complete and sign the CDPHP Member Enrollment Form.
3. Provide proof of business and/or employment (Schedule C and Schedule SE forms from your tax return; or applicable tax documentation). All taxes documents must be signed and dated.
4. Submit check made payable to Jannotti Insurance Agency for the first month's premium.
5. Return all of the above documents to this office for processing.



20 Browns Drive
New Windsor, NY 12553

(845) 564-2942

FAX (845) 567-9013

WWW.JIABENEFITS.COM

Sole Proprietors

AvidCare 25/40	Single: \$473.81	Employee + 1: N/A	Family: \$1160.55
PPO HSA	Single: \$329.17	Employee + 1: \$623.34	Family: \$819.73
EPO	Single: \$397.19	Employee + 1: \$759.38	Family: \$1001.17

Small Group (2-50 Employees)

AvidCare 25/40	Single: \$419.91	Employee + 1: N/A	Family: \$1022.30
PPO HSA	Single: \$293.05	Employee + 1: \$551.10	Family: \$723.37
EPO	Single: \$352.72	Employee + 1: \$670.44	Family: \$882.55

PLEASE NOTE THAT IT TAKES APPROXIMATELY 2-4 WEEKS FROM THE DATE APPLICATION IS SUBMITTED BEFORE YOU WILL RECEIVE YOUR IDENTIFICATION CARDS.

Membership Application

Tri-State Chamber of Commerce

Please complete this application and share the benefits of membership

APPLICATION IS HEREBY MADE FOR MEMBERSHIP IN THE TRI-STATE CHAMBER OF COMMERCE, WITH FULL PRIVILEGES AND BENEFITS DERIVED FROM PARTICIPATING IN PROGRAMS THAT PROMOTE BUSINESS AND IMPROVE THE QUALITY OF LIFE IN THE REGION
(PLEASE CALL 845-856-6694 OR E-MAIL INFO@TRISTATECHAMBER.ORG)

Company Name _____

Representative _____ Title _____

Company Address _____ P.O.Box if any _____

City, State, Zip _____ Type of Business (Category) _____

Telephone _____ (Cell) _____ Fax _____

Web Site Address _____ E-Mail _____

Check here if you do NOT wish your e-mail published _____

Check here if you do NOT wish your Fax number published _____

OUR ANNUAL INVESTMENT WILL BE _____ (PAYABLE IN ADVANCE)

Sponsor (if any) _____ Your Signature _____

Date _____ How did you hear about the Chamber? _____

Membership is Continuous unless cancelled in writing.

Investment Schedule

ACCOMMODATIONS	\$185.00	MANUFACTURERS	\$280.00 + \$1.15 per employee (full or part time)
BANKS	\$336.00	MEDIA	\$390.00
GENERAL INVESTMENT	\$185.00	RESTAURANTS	\$185.00
INDIVIDUALS	\$90.00		

Please indicate one or two major benefits you expect from the Chamber (optional-on Back)

CATEGORY LIST:

- | | | | |
|--------------------------|---------------------------|--------------------|--------------------------|
| Accommodations | Churches / Synagogues | Health Care | Restaurants |
| Accounting / Bookkeeping | Communications | Import / Export | Retail |
| Appliance Repair | Contractors | Individual Members | Schools / Colleges |
| Architects / Engineers | Dairy Farms | Insurance | Sporting clubs |
| Artists / Crafters | Deli / Convenience | Internet | Storage |
| Attorneys | Economic Development | Locksmiths | Tattoo Parlors |
| Attractions | Employment Services | Manufacturing | Taxis |
| Auto- Sales / Service | Event Planning | Marketing | Transportation |
| Banks | Financial-Planning | Media | Utilities |
| Beauty Salons | Fitness | Messenger Service | Vending Machines |
| Campgrounds | Florists / Garden Centers | Organizations | Veterinarians |
| Camps | Funeral Homes | Printers | Website Design / Support |
| Canoeing / Rafting | Golf Courses | Real Estate | Wineries |
| Cleaning Services | Graphic Design | | |



Patron Creek Corporate Center
1223 Washington Avenue • Albany, NY 12206-1057
(518) 641-5000 or 1-800-993-7299

EMPLOYER USE

Date hired ____/____/____ Date of status change ____/____/____
 Part-time Temporary to permanent
 Union to non-union Other
 Date coverage is to be effective: _____
 Group/Division #: _____
 Employee Status: A. Full-time Part-time (hours per week) _____
 B. Active Retiree Salaried Union Other

Group Administrator Initials (required) _____
 6a. Employer Name _____
 6b. Chamber/Association _____
 7. Primary language if other than English: _____

4. Your Social Security # _____
 5. Telephone: _____
 Home: (____) _____ - _____
 Work: (____) _____ - _____

Check Type of Coverage: AvidCare (CDPHP HMO) AdaptaCare (CDPHP UBI POS)

1. First Name _____ M.I. _____ Last Name _____
 2. Street Address _____ Apt. # _____
 3. City _____ State _____ County _____ Zip Code _____

SUBSCRIBER	Add Date	Name: Indicate different last names, if applicable. List oldest dependents first.	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	Physician First and Last Name	Physician Office Location	Physician Number	If current patient
<input type="checkbox"/>		Self	/ /	Self		A / /		PCP			<input type="checkbox"/>
<input type="checkbox"/>		M	/ /	M		B / /		OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>		Husband	/ /	Husband		A / /		PCP			<input type="checkbox"/>
<input type="checkbox"/>		Wife	/ /	Wife		B / /		OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>		Other	/ /	Other		A / /	<input type="checkbox"/> Yes	PCP			<input type="checkbox"/>
<input type="checkbox"/>		Son	/ /	Son		B / /	<input type="checkbox"/> No	OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>		Daughter	/ /	Daughter		A / /	<input type="checkbox"/> Yes	PCP			<input type="checkbox"/>
<input type="checkbox"/>		Son	/ /	Son		B / /	<input type="checkbox"/> No	OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>		Daughter	/ /	Daughter		A / /	<input type="checkbox"/> Yes	PCP			<input type="checkbox"/>
<input type="checkbox"/>		Son	/ /	Son		B / /	<input type="checkbox"/> No	OB/GYN			<input type="checkbox"/>
<input type="checkbox"/>		Daughter	/ /	Daughter		A / /	<input type="checkbox"/> Yes	PCP			<input type="checkbox"/>
<input type="checkbox"/>		Son	/ /	Son		B / /	<input type="checkbox"/> No	OB/GYN			<input type="checkbox"/>

Full-time college students age 19 and over: _____ Expected Date of Graduation: _____
 School Name and Address: _____
 Do you have a disabled dependent beyond age 19?
 No Yes (list name[s]): _____

11. DEPENDENT

Relationship: Self Spouse Child
 Date of Birth: ____/____/____
 Policy #: _____ Effective Date: _____
 Insurance Carrier: _____
 Address: _____
 Telephone: _____
 Covered Individuals: _____
 Employer Name: _____
 Plan Type: Self Only Self & Family Hospital Medical Drug Dental Vision
 Coverage Type: _____

12. OTHER INSURANCE

13. SIGNATURE

AGREEMENT: I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge and that I have read the important information on the reverse side of this form.
 Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Applicant's Signature _____ Date _____



CDPHP Universal Benefits, Inc.
 Patroon Creek Corporate Center
 1223 Washington Avenue • Albany, NY 12206-1057
 (518) 641-5000 or 1-800-993-7299

EMPLOYER USE

Date hired ____/____/____ Date of status change ____/____/____
 Part- to full-time Temporary to permanent
 Union to non-union Other
 Date coverage is to be effective: _____
 Group/Division #: _____
 Employee Status: A. Full-time Part-time (hours per week) _____
 B. Active Retiree Salaried Union Other
Group Administrator Initials (required) _____

1. First Name _____ **M.I.** _____ **Last Name** _____
2. Street Address _____ **Apt. #** _____
3. City _____ **State** _____ **Zip Code** _____
4. Your Social Security # _____
5. Telephone: _____
 Home: (____) _____ - _____
 Work: (____) _____ - _____
6A. Employer Name _____
6B. Chamber/Association _____
7. Primary language if other than English: _____

Subscriber ID	Name: Indicate different last names, if applicable. List oldest dependents first. M.I. Last	Date of Birth (mm/dd/yy)	Relationship	Social Security Number	Medicare A & B* Effective Date *Copy of Medicare Card must be attached.	Full-Time Student	Previous Health Care Coverage Effective Dates (Include copy of HIPAA Cert.)
<input type="checkbox"/>	Self	/ /	Self <input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No
<input type="checkbox"/>	Husband	/ /	Husband <input type="checkbox"/> Wife <input type="checkbox"/> Other		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No
<input type="checkbox"/>	Son	/ /	Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No
<input type="checkbox"/>	Son	/ /	Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No
<input type="checkbox"/>	Son	/ /	Son <input type="checkbox"/> Daughter		<input type="checkbox"/> A / / <input type="checkbox"/> B / /	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes Dates: / / to / / <input type="checkbox"/> No

8. MEMBER INFORMATION

Full-time college students age 19 and over: _____
 School Name and Address: _____
 Expected Date of Graduation: _____

9. DEPENDENT

Do you have a disabled dependent beyond age 19?
 No Yes (list name[s]): _____

Other Coverage—Do you, your spouse, or any of your dependents have any other medical insurance that will be maintained in addition to CDPHP? Yes If yes, complete below. No

Policyholder name: _____
 Social Security Number: _____
 Insurance Carrier: _____
 Address: _____
 Telephone: _____
 Relationship: Self Spouse Child
 Date of Birth: ____/____/____
 Policy #: _____ Effective Date: _____
 Employer Name: _____
 Covered Individuals: _____

10. OTHER INSURANCE

Plan Type: Self Only Self & Family Hospital Medical Drug Dental Vision
 Coverage Type: Hospital Medical Drug Dental Vision

Tri State Chamber of Commerce 2008 Chamber EPO \$25 Transitional Plan Benefit Summary

	Your Out-of-Pocket Responsibility
Annual Deductible	\$500 single, \$1,250 family
Coinsurance	20%
Coinsurance Maximum	\$2,000 single, \$5,000 family
Visit Copayment	\$25
Annual Benefit Maximum	\$1,000,000
Physician Services (not subject to the deductible)	
Office visits for illness or injury, or second opinion	\$25 copayment
Well-baby and well-child care, including immunizations/inoculations	Covered in full
Annual adult exam	Covered in full
Annual gynecological exam	Covered in full
Hospital Services	
Inpatient hospital (semi-private room, anesthesia, X-ray, lab tests, etc.)	Deductible then 20%
Physician visits during inpatient stay	Deductible then covered in full
Outpatient surgery	Deductible then 20%
Diagnostic Testing (not subject to the deductible)	
Laboratory services (<i>copayment waived if provider is a designated laboratory</i>)	\$25 copayment
Radiology and imaging (X-rays, ultrasounds, CT scans, etc.) (<i>copayment waived at designated sites</i>)	\$25 copayment
Mammogram	Covered in full
Cytology screening	Covered in full
Prostate cancer screening	Covered in full
Maternity	
Physician services	Deductible then 20%
Inpatient hospital services	Deductible then 20%
Newborn nursery	Deductible then covered in full
Emergency Care	
Worldwide emergency room care	Deductible then 20% (<i>coinsurance waived if admitted</i>)
Ambulance	Deductible then 20%
Urgent care – nonparticipating Urgent Care facility services within the CDPHP UBI service area are not covered	Visit copayment plus \$10 (not subject to the deductible)
Physical Therapy (up to 30 visits per benefit period)	\$25 (<i>not subject to the deductible</i>)
Speech Therapy	Not covered
Occupational Therapy (up to 30 visits each per benefit period)	\$25 (<i>not subject to the deductible</i>)
Chiropractic Benefits	\$25 (<i>not subject to the deductible</i>)

Home Health Care	Deductible (not to exceed \$50) then 20%
Skilled Nursing Facility	Not covered
Prosthetic Devices and Durable Medical Equipment (DME) (not subject to deductible)	50% coinsurance \$25,000 lifetime maximum
Diabetic Care (not subject to deductible)	
Insulin and oral medications – up to 30 day supply	\$15 copayment
Diabetic supplies (needles, syringes, etc.) – up to 30 day supply	\$15 copayment
Glucometers	\$15 copayment
Diabetic DME	\$15 copayment
Mental Health Services (<i>not subject to deductible</i>)	
Outpatient mental health, up to 20 visits per benefit period	\$25 copayment
Inpatient mental health, up to 30 days per benefit period	20% coinsurance
<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 Treatment Services (<i>not subject to deductible</i>)	
Outpatient services, up to 60 visits per calendar year	\$25 copayment
Inpatient detoxification services	Not covered
Inpatient rehabilitation services	Not covered
Dependent Coverage	Up to age 19

CDPHP UBI gives you access to more than 8,000 participating practitioners and providers, 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 UBI marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

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. Please note: All non-emergency health services must be provided by a CDPHP Universal Benefits, Inc. (CDPHP UBI) participating physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP UBI.

Tri State Chamber of Commerce

2008 EPO RIDERS

Dependent

Extends eligibility to full-time student dependents until age 25, including out-of-area coverage of prior approved, non-routine covered services.

Domestic Partner

Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children. Supporting documentation is required.

Chemical Abuse

Adds 7 days per benefit period for inpatient detoxification and 30 days rehabilitation per benefit period for chemical abuse and dependency treatment, including all facility, diagnostic and physicians' charges, subject to deductible then coinsurance. Inpatient chemical abuse and dependency detoxification and rehabilitation services are not covered Out-of-Network.

Prescription -drug benefits as follows:

- \$4 copayment for 30-day supply of covered generic drugs.
- \$30 copayment for 30-day supply of covered formulary brand drugs.
- \$60 copayment for 30-day supply of non-formulary brand drugs.
- Mail order: 2.5 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 require preauthorization and must be obtained at CDPHP's participating specialty vendors.
- Prescription drug benefit is capped at \$2,000 per benefit period.

This summary does not detail all benefits, limitations or exclusions. This is not a contract and may be subject to change. Membership Certificate is available for your review upon request. All benefits are subject to coordination of benefits (COB).

Tri State Chamber of Commerce

2008 CDPHP HMO \$25/\$40 Benefit Summary

Services	Copayment
Physician Services	
Office visits for illness or injury, or second opinion	\$25 per visit
Physician visits during inpatient stay	Covered in Full
Well baby and child care, including immunizations/inoculations	Covered in Full
Annual adult exam	Covered in Full
Annual gynecological exam	Covered in Full
Hospital Services	
Inpatient hospital (semi-private room, anesthesia, X-ray, lab tests, etc.)	\$500
Outpatient surgery	\$75
Diagnostic Testing	
Laboratory services (<i>copayment waived if provider is a designated laboratory</i>)	\$40
Radiology and imaging (X-rays, ultrasounds, CT scans, etc.) (<i>copayment waived at designated sites</i>)	\$40
Mammogram	Covered in Full
Cytology Screening	Covered in Full
Prostate cancer screening	Covered in Full
Maternity	
Physician services	Covered in Full
Inpatient hospital services	\$500
Newborn nursery	Covered in Full
Emergency Care	
Worldwide emergency room care	\$100 (waived if admitted)
Ambulance	\$100
Urgent care – Non participating Urgent Care facility services within CDPHP’s service area not covered	\$25 plus \$10
Physical Therapy (up to 30 visits per benefit period)	\$40
Speech Therapy (up to 20 visits benefit period)	\$40
Occupational Therapy (up to 30 visits each per benefit period)	\$40
Chiropractic Benefits	\$40
Home Health Care	Covered in Full
Skilled Nursing Facility – up to 45 days per benefit period	\$500
Prosthetic Devices and Durable Medical Equipment (DME)	50%
Diabetic Care	
Insulin and oral medications - up to 30 day supply	\$15
Diabetic supplies (needles, syringes, etc.) - up to 30 day supply	\$15
Glucometers	\$15
Diabetic DME	\$15
Mental Health Services	
Outpatient Mental Health, up to 20 visits per benefit period	\$30
Inpatient Mental Health, up to 30 days per benefit period	\$500
Chemical Abuse and Dependency Treatment Services	
Outpatient Services, up to 60 visits per calendar year	\$25 per visit
Inpatient Detoxification Services, Up to 7 days per benefit period	\$500
Inpatient Rehabilitation Services, up to 30 days per benefit period	\$500

Dependent Coverage**Up to age 19**

CDPHP gives you access to more than 9,000 participating practitioners and providers, 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 CDPHP's marketing department at (518) 641-5000 or 1-800-993-7299 or visit our Web site at www.cdphp.com.

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. Please note: All non-emergency health services must be provided by a Capital District Physicians' Health Plan, Inc. (CDPHP) participating physician/provider (including hospital admissions) unless otherwise preauthorized by CDPHP.

Tri State Chamber of Commerce

2008 HMO RIDERS

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

Dependent Eligibility

Extends eligibility to full-time student dependents until age 25, including out-of-area coverage of prior approved, non-routine covered services.

Domestic Partner

Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children. Supporting documentation is required.

Prescription Rx

Prescription drug benefits as follows:

- \$10 copayment for 30-day supply of covered generic drugs.
- \$30 copayment for 30-day supply of covered brand-name drugs.
- \$50 copayment for 30-day supply of non-formulary drugs.
- Mail order: 2.5 copayments for 90-day supply
- Prescriptions must be written by a participating practitioner and filled at a participating pharmacy, unless otherwise authorized in advance by CDPHP.
- Prescription drug benefit is capped at \$2,000 annually.

Modify Subscriber Criteria

(Medicare Split Family)

2008 High Deductible PPO Benefit Summary P11S07

(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)	\$1,500 single, \$3,000 family	\$5,000 single, \$10,000 family
Coinsurance	10% (See also DME below)	30%
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		
Pre-existing Condition Waiting Period – Not applicable to pregnancy or newborns	Pre-existing Condition Waiting Period Applies	
Services	Your Out-of-Pocket Responsibility	Your Out-of-Pocket Responsibility
Physician Services		
Office visits for illness or injury, or second opinion	Deductible then 10%	Deductible then 30%
Well-baby and well-child care including immunizations/inoculations	Covered in full	Deductible then 30%
Annual adult exam	Covered in full	Deductible then 30%
Annual gynecological exam	Covered in full	Deductible then 30%
Hospital Services		
Inpatient hospital (semi-private room, anesthesia, x-ray, lab tests, etc.)	Deductible then 10%	Deductible then 30%
Outpatient surgery	Deductible then 10%	Deductible then 30%
Diagnostic Testing		
Laboratory services	Deductible then 10% <i>(coinsurance waived when a designated laboratory provider is used)</i>	Deductible then 30%
Radiology and imaging <i>(X-rays, ultrasounds, CT scans, etc.)</i>	Deductible then 10% <i>(coinsurance waived at designated sites)</i>	Deductible then 30%
Mammogram	Covered in full	Deductible then 30%
Cytology screening,	Covered in full	Deductible then 30%
Prostate Cancer screening	Covered in full	Deductible then 30%
Maternity		
Physician services	Deductible then 10%	Deductible then 30%
Inpatient Hospital Services	Deductible then 10%	Deductible then 30%
Newborn nursery	Deductible then covered in full	Deductible then 30%
Emergency Care		
Worldwide emergency room care	Deductible then 10%	All emergency care is considered in-network.
Ambulance	Deductible then 10%	
Urgent Care - non participating Urgent Care facility services within CDPHP's UBI service area not covered	Deductible then 10%	Deductible then 10%

Services	In-Network	Out-of-Network
	Your Out-of-Pocket Responsibility	Your Out-of-Pocket Responsibility
Physical Therapy - limit 30 visits per benefit period in and out of network combined	Deductible then 10%	Deductible then 30%
Speech Therapy - limit 20 visits per benefit period in and out of network combined	Deductible then 10%	Deductible then 30%
Occupational Therapy - limit 30 visits per benefit period in and out of network combined	Deductible then 10%	Deductible then 30%
Chiropractic Benefits	Deductible then 10%	Deductible then 30%
Home Health Care	Deductible then 10%	Deductible then 30%
Skilled Nursing Facility – Up to 45 days per benefit period	Deductible then 10%	Deductible then 30%
Prosthetic Devices and Durable Medical Equipment (DME)	Deductible then 50% <i>Limited to \$25,000 per lifetime</i>	Covered in network only
Mental Health Services		
Outpatient mental health services - up to 20 visits per benefit period	Deductible then 10%	Deductible then 30%
Inpatient mental health services - up to 30 days per benefit period	Deductible then 10%	Deductible then 30%
<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 30%
Inpatient detoxification - Up to 7 days per benefit period	Deductible then 10%	Not Covered
Inpatient rehabilitation - Up to 30 visits per benefit period	Deductible then 10%	Not Covered
Diabetic Care		
Insulin and oral medications – Up to 30 day supply	\$15	Deductible then 30%
Diabetic supplies (needles, syringes, etc.) – Up to 30 day supply	\$15	Deductible then 30%
Glucometers	\$15	Deductible then 30%
Diabetic DME	\$15	Deductible then 30%

Dependent Coverage

To age 19

The High Deductible PPO 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 CDPHP UBI's 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 deductible and/or coinsurance. Additional payments for failure to comply with CDPHP UBI's managed benefits program do not apply to the annual Out-of-Pocket Maximum. 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 Insurance Department. It does not provide major medical insurance.

Tri State Chamber of Commerce

2008 HDPPO PLAN RIDERS

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

Dependent Eligibility

Extends eligibility to full-time student dependents until age 25, including out-of-area coverage of prior approved, non-routine covered services.

Medicare Split

A dependent spouse of a Medicare-eligible subscriber may enroll as a subscriber providing he or she is not Medicare-eligible.

Domestic Partner

Provides coverage for an eligible same or opposite sex domestic partner and his or her eligible dependent children. Supporting documentation is required.

Prescription Rx(subject to Plan Deductible)

Prescription drug benefits as follows:

- \$10 copayment for 30-day supply of covered generic drugs.
- \$30 copayment for 30-day supply of covered formulary brand drugs.
- \$50 copayment for 30-day supply of non-formulary brand drugs.
- Mail order: 2.5 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 require preauthorization and must be obtained at CDPHP's participating specialty vendors.
- Prescription drug benefit is capped at \$1,000 annually.