# IBEW Local #236
## HDPPO Plan
## 1/1/2019

| | In Network | Out of Network |
|---|---|---|
| **Deductible** | $2,500 Single<br>$5,000 2 Person<br>$7,500 Family | $3,000 Single<br>$6,000 2 Person<br>$9,000 Family |
| **Coinsurance** | Not Applicable | 30% Coinsurance |
| **Office Visits** | | |
| PCP | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Specialist | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| **Out of Pocket Maximum** | $6,600 Single<br>$13,200 2 Person<br>$13,200 Family | $6,000 Single<br>$12,000 2 Person<br>$18,000 Family |
| **Benefit Maximum** | Unlimited | Unlimited |
| **Physician Services** | | |
| PCP Office Visits for illness, injury or second opinion | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Specialist Office Visits for illness, injury or second opinion | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Telemedicine by Doctor on Demand | Deductible then Covered in Full | Covered In-Network Only |
| Physician visits during inpatient stay when billed separately from the facility | Covered in Full | Deductible then 30% Coinsurance |
| Well Baby and Child Care including immunizations and inoculations | Covered in Full | Deductible then 30% Coinsurance |
| Annual Adult Exam | Covered in Full | Deductible then 30% Coinsurance |
| Annual Gynecological Exam | Covered in Full | Deductible then 30% Coinsurance |
| **Hospital Services** | | |
| Inpatient Hospital (semi-private room, anesthesia, X-Ray, lab test, etc) | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Outpatient Surgery | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| **Emergency Care** | | |
| Worldwide Emergency Room Care | Deductible then Covered in Full | All Emergency Care is Considered In Network |
| Ambulance | Deductible then Covered in Full | All Emergency Care is Considered In Network |
| **Urgent Care** | Deductible then Covered in Full | Deductible then 30% Coinsurance |

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| **Diagnostic Testing***<br>Outpatient Hospital Laboratory Services<br>*Copayment waived if provider<br>is a designated laboratory | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Outpatient Hospital Radiology Services<br>*Copayment waived if provider is<br>a preferred center | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Office Based Laboratory Services<br>*Copayment waived if provider<br>is a designated laboratory | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Office Based Radiology Services<br>*Copayment waived if provider is<br>a preferred center | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Mammogram | Covered in Full | Deductible then 30% Coinsurance |
| Cytology Screening | Covered in Full | Deductible then 30% Coinsurance |
| Prostate Cancer Screening | Covered in Full | Deductible then 30% Coinsurance |
| **Physical Therapy**<br>In Network and Out of Network<br>visits are counted toward maximum | Deductible then Covered in Full<br><br>(30 visits per benefit period) | Deductible then 30% Coinsurance |
| **Speech Therapy**<br>In Network and Out of Network<br>visits are counted toward maximum | Deductible then Covered in Full<br><br>(20 visits per benefit period) | Deductible then 30% Coinsurance |
| **Occupational Therapy**<br>In Network and Out of Network<br>visits are counted toward maximum | Deductible then Covered in Full<br><br>(30 visits per benefit period) | Deductible then 30% Coinsurance |
| **Chiropractic Beneftis** | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| **Home Health Care** | Covered in Full | Deductible then 30% Coinsurance |
| **Skilled Nursing Facility** | Deductible then Covered in Full<br>(45 days per benefit period) | Deductible then 30% Coinsurance |
| **Prosthetic Appliance and Durable Medical Equipment**<br><br>There is no lifetime maximum for durable medical equipment, prosthetics, orthotics, and oxygen. DME is not covered out of network. There is no coverage for orthotic shoe inserts. | Deductible then Covered in Full | Covered In-Network Only |

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| **Vision** | | |
| Routine Eye Exam one exam per year | Deductible then Covered in Full | Covered In-Network Only |
| **Diabetic Services** | | |
| Insulin and oral Medicaiton - up to a 30 day supply | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Diabetic Supplies (needles and syringes) - up to a 30 day supply | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Glucometers | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Diabetic DME | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| **Mental Health** | | |
| Inpatient | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Outpatient | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| **Chemical Abuse and Dependency Services** | | |
| Inpatient Detox | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Outpatient | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Inpatient Rehabilitation Services | Deductible then Covered in Full | Deductible then 30% Coinsurance |
| Dependent Coverage | Covered to Age 26 | Covered to Age 26 |

This summary is provided to highlight some specific provisions of the plan. Some restrictions may apply. Please refer to your Summary Plan Description for more detailed information including limitations and exclusions. All benefits of the plan are subject to coordination of benefits. This plan is sponsored by IBEW Local #236 and administered by Capital District Physicians' Healthcare Network, Inc. (CDPHN). While this material is believed to be accurate as of the print date, it is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

**Questions?** CDPHN can answer questions and provide information about the benefits available under this plan. Just visit the Web site at www.cdphp.com or call (518) 641-3100 or 1-877-724-2579 from 8 a.m. to 5 p.m. Eastern Standard Time. The TTY number is (518) 641-4000 or toll free 1-877-261-1164.