IBEW Local #236
PPO Plan
01/01/2019

	In Network	Out of Network
Deductible	N/A Single / N/A Family (Embedded)	$1,000 Single / $3,000 Family (Embedded)
Coinsurance	Not Applicable	30% Coinsurance
Office Visits		
PCP	$25 Copayment	Deductible then 30% Coinsurance
Specialist	$25 Copayment	Deductible then 30% Coinsurance
Out of Pocket Maximum	$6,600 Single / $13,200 Family	$6,000 Single / $13,000 Family
Benefit Maximum	Unlimited	Unlimited
Physician Services		
PCP Office Visits for illness, injury or second opinion	$25 Copayment	Deductible then 30% Coinsurance
Specialist Office Visits for illness, injury or second opinion	$25 Copayment	Deductible then 30% Coinsurance
Telemedicine by Doctor on Demand	$25 Copayment	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 tests, etc)	$240 Copayment	Deductible then 30% Coinsurance
Outpatient Surgery	$100 Copayment	Deductible then 30% Coinsurance
Maternity		
Physician Services when billed separately from the facility	Covered in Full	Deductible then 30% Coinsurance
Inpatient Hospital Services	$240 Copayment	Deductible then 30% Coinsurance
Newborn Nursery	Covered in Full	Deductible then 30% Coinsurance
Emergency Care		
Worldwide Emergency Room Care	$50 Copayment	All Emergency Care is Considered In Network
Ambulance	$50 Copayment	All Emergency Care is Considered In Network
Urgent Care	$35 Copayment	Deductible then $35 Copayment

Services (Cont.)	In Network	Out of Network
Diagnostic Testing*		
Outpatient Hospital Laboratory Services * Copayment waived if provider is a designated laboratory.	$25 Copayment	Deductible then 30% Coinsurance
Outpatient Hospital Radiology Services * Copayment waived if is a preferred center.	$25 Copayment	Deductible then 30% Coinsurance
Office Based Laboratory Services * Copayment waived if provider is a designated laboratory.	$25 Copayment	Deductible then 30% Coinsurance
Office Based Radiology Services * Copayment waived if is a preferred center.	$25 Copayment	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 In network and Out of Network visits are counted toward maximum	$25 Copayment (30 visits per benefit period)	Deductible then 30% Coinsurance
Speech Therapy In network and Out of Network visits are counted toward maximum	$25 Copayment (20 visits per benefit period)	Deductible then 30% Coinsurance
Occupational Therapy In network and Out of Network visits are counted toward maximum	$25 Copayment (30 visits per benefit period)	Deductible then 30% Coinsurance
Chiropractic Benefits	$25 Copayment	Deductible then 30% Coinsurance
Home Health Care	Covered in Full	Deductible then 25% Coinsurance
Skilled Nursing Facility	$240 Copayment (45 days per benefit period)	Deductible then 30% Coinsurance
Prosthetic Appliances and Durable Medical Equipment 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.	50% Coinsurance	Covered In-Network Only

Services (Cont.)	In Network	Out of Network
Diabetic Services		
Insulin and oral Medication - up to a 30 day supply	$15 Copayment	30% Coinsurance
Diabetic Supplies (needles and syringes) - up to a 30 day supply	$15 Copayment	30% Coinsurance
Glucometers	$15 Copayment	30% Coinsurance
Diabetic DME	$15 Copayment	30% Coinsurance
Vision		
Routine Eye Exam One exam per year	$15 Copayment	Covered In-Network Only
Mental Health Services		
Inpatient	$240 Copayment	Deductible then 30% Coinsurance
Outpatient	$25 Copayment	Deductible then 30% Coinsurance
Chemical Abuse and Dependency Services		
Inpatient Detox	$240 Copayment	Deductible then 30% Coinsurance
Outpatient	$25 Copayment	Deductible then 30% Coinsurance
Inpatient Rehabilitation Services	$240 Copayment	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.cdphn.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.