



**IBEW Local #236
HDPPO Plan**

	In Network	Out of Network
Deductible	\$2,500 Single \$5,000 2 Person \$7,500 Family	\$3,000 Single \$6,000 2 Person \$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 \$13,200 2 Person \$13,200 Family	\$6,000 Single \$12,000 2 Person \$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

Diagnostic Testing*

Outpatient Hospital Laboratory Services *Copayment waived if provider is a designated laboratory	Deductible then Covered in Full	Deductible then 30% Coinsurance
Outpatient Hospital Radiology Services *Copayment waived if provider is a preferred center	Deductible then Covered in Full	Deductible then 30% Coinsurance
Office Based Laboratory Services *Copayment waived if provider is a designated laboratory	Deductible then Covered in Full	Deductible then 30% Coinsurance
Office Based Radiology Services *Copayment waived if provider is 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

In Network and Out of Network visits are counted toward maximum	Deductible then Covered in Full (30 visits per benefit period)	Deductible then 30% Coinsurance
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Speech Therapy

In Network and Out of Network visits are counted toward maximum	Deductible then Covered in Full (20 visits per benefit period)	Deductible then 30% Coinsurance
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Occupational Therapy

In Network and Out of Network visits are counted toward maximum	Deductible then Covered in Full (30 visits per benefit period)	Deductible then 30% Coinsurance
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Chiropractic Benefits

Deductible then Covered in Full	Deductible then 30% Coinsurance
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Home Health Care

Covered in Full	Deductible then 30% Coinsurance
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Skilled Nursing Facility

Deductible then Covered in Full (45 days per benefit period)	Deductible then 30% Coinsurance
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Prosthetic Appliance and Durable Medical Equipment

Deductible then Covered in Full	Covered In-Network Only
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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.

Vision

Routine Eye Exam one exam per year	Deductible then Covered in Full	Covered In-Network Only
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Diabetic Services

Insulin and oral Medicaiton - up to a 30 day supply	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Diabetic Supplies (needles and syringes) - up to a 30 day supply	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Glucometers	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Diabetic DME	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Mental Health

Inpatient	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Outpatient	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Chemical Abuse and Dependency Services

Inpatient Detox	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Outpatient	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Inpatient Rehabilitation Services	Deductible then Covered in Full	Deductible then 30% Coinsurance
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Dependent Coverage	Covered to Age 26	Covered to Age 26
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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.