2022 Local 773 EPO High

	In-Network	Out-of-Network
Annual Deductible		
Individual Coverage	**$750**	**N/A**
Family Coverage	**$1,875**	**N/A**
Coinsurance	**N/A**	**N/A**
Out-of-Pocket Maximum		
Individual Coverage	**$2,000**	**N/A**
Family Coverage	**$5,000**	**N/A**
Lifetime Maximum Coverage	**N/A**	**N/A**
Physician Services		
Office visits - PCP	**$35 copayment**	**Not Covered**
Office visits – Specialist	**$35 copayment**	**Not Covered**
Well baby and child care	**Covered in Full**	**Not Covered**
Well Adult exam	**Covered in Full**	**Not Covered**
Routine GYN exam	**Covered in Full**	**Not Covered**
Emergency Care		
Hospital Facility	**$200 Copayment** *Copayment waived if admitted within 24 hours	**$200 Copayment**
Ambulance	**Deductible then $35 copay**	**Deductible then $35 copay**
Urgent Care	**$35 Copayment**	**$50 Copayment**
Hospital Services		
Inpatient Hospital (semi-private room)	**Deductible then $35 copay**	**Not Covered**
Physician	**Deductible then $35 copay**	**Not Covered**
Outpatient Surgery Hospital	**Deductible then $35 copay**	**Not Covered**
Outpatient Surgery Facility	**Deductible then $35 copay**	**Not Covered**
Diagnostic Testing		
Laboratory services	**Deductible then $35 copay**	**Not Covered**
Radiology and Imaging (X-rays, MRI's)	**Deductible then $35 copay** *See SPD for details on these services	**Not Covered**
Maternity		
Physician services (pre/post natal care)	**Deductible then $35 copay**	**Not Covered**
Delivery	**Deductible then $35 copay**	**Not Covered**
Newborn nursery	**Deductible then $35 copay**	**Not Covered**

Chiropractic care, Physical Therapy, Occupational Therapy and Respiratory Therapy	**Deductible then $35 copay**	**Not Covered**
	*See SPD for limitations on these services	
Durable Medical Equipment and Prosthetic Devices	**Deductible then $35 copay**	**Not Covered**
	Prior authorization required for items in excess of $500	
Chemical Abuse & Dependency		
Inpatient Detoxification	**Deductible then $35 copay**	**Not Covered**
Inpatient Rehabilitation	**Deductible then $35 copay**	**Not Covered**
Outpatient Facility Rehabilitation	**Deductible then $35 copay**	**Not Covered**
	*See SPD for limitations on these services	
Mental Health		
Office Visit	**$35 Copayment**	**Not Covered**
Inpatient	**Deductible then $35 copay**	**Not Covered**
Outpatient Facility	**$35 Copayment**	**Not Covered**
	*See SPD for limitations on these services	
Vision *Once every 24 months for adults, once every 12 months for dependents under 19		
Eye Exam	**$10 Copayment**	**Not Covered**
Glasses or Contacts	**$250 Allowance**	
Prescription Drug Coverage		
Not administered by CDPHP; please contact Express Scripts 1-866-544-2930		

This plan is sponsored by Local 773 and administered by Capital District Physicians' Healthcare Network, Inc. (CDPHN).

This summary is provided to highlight some specific provisions of the plan. Some restrictions may apply. This plan does not cover services that are not medically necessary, for example: cosmetic procedures, LASIK surgery. 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.

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 the 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 1-877-261-1164. For language assistance please call member services.