Labor-Management Healthcare Coalition®
Independent Health Passport PPO (formerly 201)
Summary of Benefits

Deductibles/Maximums	In- Network	Out-of-Network
Deductible	$0	$0
Out-of-Pocket Maximum	$3,000 In Network	$3,000 Combined in and out of network
Residency Restrictions	Must be WNY resident for six months each year	
Prescription Drug		
Prescription copay	$10/$20/$95	
Mail order copay per 90-day supply	1 copay	
Option 90 - 90 day supply at retail	2.5 copays	
Preventive Services	In- Network	Out-of-Network
Abdominal aortic aneurysm screening	Covered in full	$20 copayment
Annual Physical Exam	Covered in full	$20 copayment
Basic Metabolism Test	Covered in full	$20 copayment
Bone Mass Measurement	Covered in full	$20 copayment
Cholesterol Test (Lipid Panel)	Covered in full	$20 copayment
Colonoscopy and Sigmoidoscopy	Covered in full	$20 copayment
Fecal Blood Testing	Covered in full	$20 copayment
Flu Shot	Covered in full	$20 copayment
Hemoglobin & Hematocrit Testing	Covered in full	$20 copayment
Hepatitis B Vaccine	Covered in full	$20 copayment
HIV Screening	Covered in full	$20 copayment
HPV Screening	Covered in full	$20 copayment
Mammogram	Covered in full	$20 copayment
Pap Smear	Covered in full	$20 copayment
Pneumonia Vaccine	Covered in full	$20 copayment
Prenatal & Post-partum Visits	Covered in full	$20 copayment
Prostate Exam (Prostate Specific Antigen "PSA")	Covered in full	$20 copayment
Rh Screening	Covered in full	$20 copayment
Rubella Screening	Covered in full	$20 copayment
Physician and Other Services		
Primary Care Physician	$15 copayment	$20 copayment
Specialty Physician	$15 copayment	$20 copayment
Outpatient Surgery (PCP's Visit)	$15 copayment	$20 copayment
Outpatient Surgery (Specialist's office)	$15 copayment	$20 copayment
Telemedicine Program	$20 copayment	Not Covered
Emergency & Urgent Care Services		
Emergency Room (copay waived if admitted to hospital)	$50 copayment	$50 copayment
Ambulance	$50 copayment	$50 copayment
Urgent Care Center	$50 copayment	$50 copayment
Hospital and Other Family Services		
Inpatient Hospital	$100 copayment per admission	20% Coinsurance
Outpatient Surgical Procedures (Hospital Facility)	$25 copayment	20% Coinsurance
Skilled Nursing Facility (Not Long Term Care-Rehab only) 100 days max / benefit period	$100 copayment per admission	20% Coinsurance

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Diagnostic Testing Services	In- Network	Out-of-Network
Lab Services	Covered in Full	$20 copayment
X-Rays	$15 copayment	$20 copayment
Advanced Radiology	$15 copayment	$20 copayment
Diagnostic Tests	$15 copayment	$20 copayment
Radiation Therapy	$15 copayment	$20 copayment
Mental Health & Substance Abuse		
Inpatient Mental Health / 190 day lifetime limit	Covered in Full	20% coinsurance
Outpatient Mental Health	$40 copayment-Group Therapy / $20 copayment-Psychiatrist	50% coinsurance-Group therapy / 20% coinsurance-psychiatrist
Inpatient Substance Abuse - Rehab	Covered in Full	20% coinsurance
Outpatient Substance Abuse	20% Coinsurance / Group Therapy & Psychiatrist	20% Coinsurance / Group Therapy & Psychiatrist
Rehabilitation Services		
Chiropractic - Medicare Covered	$15 copayment	$20 copayment
Physical/Occupational/Speech Therapies	$20 copayment per visit	20% coinsurance
Cardiac Rehabilitation	$20 copayment	20% coinsurance
Pulmonary Rehabilitation	$15 copayment	$20 copayment
Additional Services		
Durable Medical Equipment	20% Coinsurance	20% Coinsurance
Prosthetic Devices	Covered in Full	20% coinsurance per item
Home Health Care	Covered in Full	10% coinsurance per item
Fitness Benefit	Silver Sneakers-$0 activation fee	must be a Silver Sneaker network facility
Renal Dialysis	Covered in Full	Covered in Full
Diabetic Supplies	Lesser of $10 or 20% coinsurance per item	Lesser of $10 or 20% coinsurance per item
Medicare Covered Podiatry Services	$15 copayment	$20 copayment
Routine Foot Care - 3 Limit / Year	$15 copayment	$20 copayment
Nutritional Therapy for ESRD or Diabetes	Covered in Full	$20 copayment
Hearing Aids & Evaluation Exam	$45 copayment/$499 to $2,799 copay per ear-per year	must use a Smart Hearing Inc network provider
Vision Services - EyeMed Provider		
Medical Eye Exam	$15 copayment	$20 copayment
Routine / Refractive Exam	Covered in Full	$20 copayment
Eyewear - Routine - Annual Limit	$150 Allowance Combined In & Out of Network	$150 Allowance Combined In & Out of Network
Eyewear - Post Cataract Surgery	$150 Annual Allowance Combined In & Out of Network	$150 Annual Allowance Combined In & Out of Network

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***This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more information, consult your Evidence of Coverage.*