Labor-Management Healthcare Coalition ®

Town of West Seneca Summary of Benefits POS 226D

Dependent/Student coverage endsEnd of birth monthDomestic partnerNo Coverage for domestic partnerPrescription DrugPrescription copayPrescription copay per 90-day supply\$10 / \$35 / \$70Mail order copay per 90-day supply at retail1 copayOption 90 - 90 day supply at retail2.5 copays	POS 226D		
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Routine physical exam Covered in full PSA test Covered in full	Routine OB/GYN	Covered in full	
PSA test Covered in full	Routine pap smear	Covered in full	
	Routine physical exam	Covered in full	
Routine eye exam Covered in full	PSA test	Covered in full	
	Routine eye exam	Covered in full	

Labor-Management Healthcare Coalition ®

Town of West Seneca Summary of Benefits POS 226D

Hospital	
Inpatient hospital stay	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Inpatient maternity stay	\$500 per admission, not to exceed \$500 single /\$1,000 family after deductible
Outpatient surgery (in physicians office)	\$25 copay /\$40 copay after deductible
Outpatient surgery (Facility)	\$100 copayment after deductible
Emergency Hospital Care	
Emergency room (copay waived if admitted to hospital)	\$150 copaymnet after deductible
Ambulance - ground ambulance	\$150 copaymnet after deductible
Ambulance - air ambulance	\$150 copaymnet after deductible
Urgent care centers	\$50 copayment after deductible
Mental Health & Substance Abuse	
Inpatient mental health	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Outpatient mental health	\$25 copayment after deductible
Inpatient alcohol & substance abuse detoxification	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Inpatient alcohol & substance abuse rehabilitation	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible
Outpatient alcohol & substance abuse	\$25 copayment after deductible
Other Services	
Chemotherapy Outpatient Facility	\$40 copayment after deductible
Dialysis	\$40 copayment after deductible
Durable medical equipment	20% coinsurance after deductible
Home health care	\$40 copayment after deductible
Hospice	Covered in full after deductible
Pulmonary Rehabilitation	\$40 copayment after deductible
Physical, speech & occupational therapy	\$40 copayment after deductible; 30 visits, aggregate IN & OON wit PT/ST/OT, per plan year
Prosthetic and orthotic appliances	20% coinsurance after deductible
Skilled nursing facility (Not Long Term Care-Rehab only)	\$500 per admission, not to exceed \$500 single/\$1,000 family after deductible

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**This is a summary of covered benefits and exclusions and is not intended as an actual contract or group plan. It does not detail all benefits, limitations and exclusions that may apply.