

**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  |   |  |
| Worldwide Emergency Room (copay waived if admitted to hospital)                           | \$50 copayment                                | \$50 copayment                         |
| Ambulance   | \$50 copayment                                | \$50 copayment                         |
| Urgent Care Center (U.S. Only)  | \$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)<br>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   |
| <b>Mental Health &amp; Substance Abuse</b>       |  |  |
| 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               |
| <b>Rehabilitation Services</b>                   |  |  |
| 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   |
| <b>Additional Services</b>                       |  |  |
| 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                |
| <b>Vision Services - EyeMed Provider</b>         |  |  |
| 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          |

revised 1/1/2025 dr

**\*\*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.**