

SUMMARY OF BENEFITS
Encompass 65 HMO (formerly 401)
Offered by Labor-Management Healthcare Coalition

Medical Services	Copay / Coinsurance
Primary care office visits for Medicare-covered services	\$10 copay
Routine physicals (1 every year)	\$0 copay
Diagnostic x-rays – Outpatient facility	\$10 copay
PCP/Specialist	\$10/\$20 copay
Laboratory testing	\$0 copay
Chiropractic care	\$15 copay
Specialist visits for Medicare-covered services	\$20 copay
Podiatry services – medically necessary	\$15 copay
Podiatry services – routine up to 3 visits every year	\$15 copay
Bone mass measurement (people at risk)	\$0 copay
Colorectal screening exam (age 50 and older)	\$0 copay
Prostate cancer screening (age 50 and older)	\$0 copay
Immunizations – Hepatitis B vaccine, pneumonia vaccine (for people at risk)	\$0 copay
Immunizations – Influenza vaccine (in network only), H1N1 vaccine	\$0 copay
Diagnostic hearing exams	\$15 copay
Women's Services	
Medicare-covered pelvic exam (High risk annually) (Low risk every 24 months)	\$0 copay
Medicare-covered Pap smear (same as above)	\$0 copay
Mammogram – Medicare-covered screening (age 40 and older)	\$0 copay
Hospital Care	
Inpatient hospital care	\$250 copay
Outpatient surgery facility	\$50 copay
Radiation therapy - Outpatient facility	\$0 copay
PCP/Specialist	\$10/\$20 copay
Cardiac rehabilitation	\$15 copay
Occupational, speech, physical therapy	\$15 copay
Emergency room visit (waived if admitted to hospital)	\$50 copay
Emergency ambulance	\$50 copay
Mental Health Care	
Inpatient (190-day lifetime limit in aggregate with Substance Abuse Treatment)	\$0 copay
Outpatient visits	\$40 copay
Mental Health services with Psychiatrist	\$20 copay
Substance Abuse Treatment	
Inpatient detoxification and rehabilitation services (190 day lifetime limit in a Psychiatric hospital)	\$0 copay
Outpatient visits	20% coinsurance
Other Services	
Diabetic self-monitoring training	\$0 copay
Durable medical equipment	20% coinsurance
Home health care	\$0 copay
Prosthetic appliances	20% copay
Skilled nursing facility (100 days each benefit period) For rehabilitation purposes – Not Long Term Care	\$0 copay
Urgent care facility (waived if admitted)	\$50 copay
Formulary Generic/Brand prescription drugs (up to a 30 day supply)	\$5 / \$10 / \$95
Mail-Order Formulary Generic/Brand prescription drugs (up to 90 day supply)	\$5 / \$10 / \$95
Out of Pocket maximum	\$3,000
Vision Care	
Routine vision exam (1 every year)	\$0 copay
Medical vision exam	\$20 copay

This is a summary of covered benefits and exclusions and is not intended as an actual contract. Copay, deductible and prescription plan variations may occur. Please check with your employer.

Revised for 2016