Labor-Management Healthcare Coalition®
Independent Health Passport PPO 799
Town of Orchard Park
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
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	Covered in full	$15 copayment
Specialty Physician	Covered in full	$20 copayment
Outpatient Surgery (PCP's Visit)	Covered in full	$15 copayment
Outpatient Surgery (Specialist's office)	Covered in full	$20 copayment
Telemedicine Program	$20 copayment	Not Covered
Emergency & Urgent Care Services		
Emergency Room (copay waived if admitted to hospital)	Covered in full	Covered in full
Ambulance	Covered in full	Covered in full
Urgent Care Center	Covered in full	Covered in full
Hospital and Other Family Services		
Inpatient Hospital	Covered in full	20% coinsurance
Outpatient Surgical Procedures (Hospital Facility)	Covered in full	20% coinsurance
Skilled Nursing Facility (Not Long Term Care-Rehab only) 100 days max/benefit period	Covered in full	20% coinsurance

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Diagnostic Testing Services	In-Network	Out-of-Network
Lab Services	Covered in Full	$20 copayment
X-Rays	Covered in Full	$20 copayment
Advanced Radiology	Covered in Full	$20 copayment
Diagnostic Tests	Covered in Full	20% coinsurance
Radiation Therapy	Covered in Full	$20 copayment
Mental Health & Substance Abuse		
Inpatient Mental Health / 190 day lifetime limit	Covered in Full	20% coinsurance
Outpatient Mental Health	Covered in Full	20% coinsurance
Inpatient Substance Abuse - Rehab	Covered in Full	20% coinsurance
Outpatient Substance Abuse	Covered in Full	20% coinsurance
Rehabilitation Services		
Chiropractic - Medicare Covered	Covered in Full	$20 copayment
Physical/Occupational/Speech Therapies	Covered in Full	$20 copayment
Cardiac Rehabilitation	Covered in Full	$20 copayment
Pulmonary Rehabilitation	Covered in Full	$20 copayment
Additional Services		
Durable Medical Equipment	Covered in Full	20% coinsurance
Prosthetic Devices	Covered in Full	20% coinsurance per item
Home Health Care	Covered in Full	$10 copayment
Fitness Benefit	Silver Sneakers - $0 activation fee	Must use a Silver Sneakers Netowrk 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	Covered in Full	$20 copayment
Routine Foot Care - 3 Limit / Year	$0 copayment	$20 copayment
Nutritional Therapy for ESRD or Diabetes	Covered in Full	20% coinsurance
Hearing Aids & Evaluation Exam	$300 toward hearing aid. $499-$2,799 copayment per year	Must use Smart Hearing Inc. network provider
Vision Services - EyeMed Provider		
Medical Eye Exam	Covered in Full	$20 copayment
Routine / Refractive Exam	Covered in Full	$20 copayment
Eyewear - Routine - Annual Limit	$100 Allowance Combined In & Out of Network	$100 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
Dental Services		
Preventive and Routine	Covered in Full / Must use Healthplex Provider	$20 copayment then 50% reimbursement of what would be paid to a network provider
Medicare Covered Dental Services (excludes comprehensive Dental Services)	Covered in Full	Covered in Full

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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.*