

benefit summary



Group : CONSTRUCTION EXCHANGE OF WNY

Group Number:	10612H
Benefit	Encompass Elect 035E
Outpatient Services	
Office Visit	\$15
Adult Immunizations	\$15
Well-Child Visits	\$0
Allergy Testing/Treatment	\$15
Chemotherapy	\$15
EKGs and Other Diagnostic Procedures	\$15
Diagnostic X-rays	\$15
Mammogram	\$0
Laboratory Testing, Including Pap Smears	\$0
Rehabilitation Therapies (physical, occupational, and speech)	\$15
Outpatient Surgical Procedures	\$15
Medical Eye Exam	\$15
Chiropractic Services	\$15
Maternity Services	
Physician Services	Prenatal / delivery / postpartum covered in full
Inpatient Hospital Services	\$240
Hospital Services	
Inpatient Hospital	\$240
Hospice	\$240
Emergency Services	
Medically Necessary Ambulance Transportation	\$25
Emergency Room	\$50
After Hours Care Center	\$35
Outpatient Mental Health Services	
Mental Health For short-term, medically necessary crisis intervention	50% copayment for up to 20 outpatient visits per member per calendar year
Substance Abuse Treatment (visit limits apply)	
Detoxification	\$240
Inpatient Rehabilitation	Not covered
Outpatient Treatment	\$15
Additional Services	
Durable Medical Equipment	Covered at 50% coinsurance, with an annual allowance of \$1,000
Prosthetics and Appliances	50% copayment
Skilled Nursing Facility	Inpatient benefit applies. (See contract/riders for limitations)
Home Care Services	\$15
Diabetic Supplies and Services	
Durable Medical Equipment (for treating Diabetes)	Primary care copayment applies
Insulin and Other Oral Agents	Primary care copayment (from the base contract), or your prescription copayment applies, whichever is less.
Up to a 30 day supply of outpatient diabetic medical supplies (test strips, syringes, etc.)	Primary care copayment applies

Vision Plan	
Vision Coverage	Premier Vision Plan
Annual Refractive Examination	Covered in full
Standard Plastic Lenses	Single Vision: \$10 Bifocal: \$10 Trifocal: \$10 Lenticular: \$10 Progressive: \$10
Lens Options	UV Coating: \$12 Tint: \$12 Standard Anti-Reflective: \$45 Standard Polycarbonate: \$35 Standard Scratch Resistance: \$12 Other Services: 20% Discount
Frames	Frames: \$60 allowance, then member pays 80% of the balance over \$60
Contact Lenses	Conventional contact lenses: \$90 allowance. 15% discount for any balance Disposable contact lenses: \$90 allowance. Specialty contact lenses: \$250 allowance (provided based on EyeMed's medically necessary criteria)
Laser Vision Correction	U.S. Laser Network for LASIK or PRK: 15% discount on standard fees or 5% off promotional pricing
Frequency Limitations	Examinations: Once every 12 months Contact Lenses: Once every 12 months Frames: Once every 12 months Lenses: Once every 12 months

Dental Plan	
Dental Coverage	Cleaning/exam, 1 per member/calendar year: \$5 member copay.

Prescription Plan	
Prescription Drug Coverage	\$10/ \$20/ \$35
Contraceptive drugs and devices	Tier I oral contraceptives @ \$0 copay

Additional Benefits	
Out-of-network benefits	Deductible: \$250/ \$500 Coinsurance: 20% Out-of-pocket maximum: \$2,000/ \$4,000

Dependent Eligibility	
Dependent Eligibility Extension	To age 19 Dependents terminate at the end of the month in which their eligibility expires.

Exclusions
 Non-Medicare plans: Items such as television set rental and phone charges while an inpatient in a Hospital*Hearing aid appliances*Cosmetic surgery, unless medically necessary*Custodial care or rest cures*Experimental medical procedures*Long-term physical therapy*Military-related disabilities*In-Vitro fertilization, gamete intrafallopian tube transfers*Physical examinations requested for employment, licensing, insurance, camp*Outpatient medical supplies (except diabetic supplies)*Dental surgery, treatment or care (Member discounts are available)**Note: Certain exclusions may not apply if your group has included a rider. All benefits of this plan are subject to coordination of benefits. This summary is designed to highlight the benefits of the plan and does not detail all benefits, limitations, exclusions or pre-existing condition exclusion rules. Please refer to the "Medical Management" section for information on pre-existing condition exclusions. It is NOT a contract and may be subject to change. For more detailed information, consult your Group Health Contract, attached Riders (if any), or Certificate of Coverage. Certain medical services require your physician to get prior approval from Independent Health. Certain medical services require you to get pre-certification from Independent Health.