

Independent Health
Western New York

Plan: Encompass D (10/50/100 RX)

#23017-01 and #23017-02 Actives

Web Site: <http://www.independenthealth.com>

Monthly Employee Contributions: **EE Only = \$132** **EE + 1 = \$314** **Family = \$360**

Benefit	2019 Actives
Annual Deductible	None (In-network); \$500 individual/\$1,000 family (Out-of-network)
Annual Out-of-pocket limit	\$6,350 individual/\$12,700 family (In-network); \$10,000 individual/\$20,000 family (Out-of-network); includes prescription drug copays
Out-of-network coinsurance	None (In-network); Member pays 25%, Plan pays 75% (Out-of-network)
Inpatient hospital Room and board Ancillary charges Special-duty nursing	\$250 copay per admission Covered in full after inpatient hospital copay Not covered
Skilled nursing facility	Covered in full after \$250 copay up to 45 days/calendar year
Surgery Inpatient Outpatient Cosmetic	Covered in full after inpatient hospital copay \$75 copay/visit in an Outpatient facility; \$20 copay/visit in a physician office; \$35 copay/visit in a specialist's office Not covered
Maternity care Obstetrical visits Hospitalization	\$20 copay first visit; covered in full thereafter \$250 copay per admission
Outpatient Office visits Routine examinations X-rays and lab work Eye examinations Eyeglasses Physical therapy Chiropractor	\$20 copay/visit Primary Care Physician (PCP); \$35 copay/visit Specialist Preventive care covered in full Lab covered 100%; X-Ray \$20 copay \$20 copay/visit for Routine eye exam; \$35 copay/visit for Medical Lenses: \$50 copay for single vision; Frames: 40% discount off of retail cost at EyeMed providers \$20 copay/visit up to 20 visits per calendar year (combined with occupational and speech therapy) \$35 copay/visit
Alcoholism and chemical dependency Detoxification Rehabilitation	Inpatient: Covered in full after inpatient hospital copay Outpatient: \$20 copay/visit (counseling services for substance abuse) Inpatient: Covered in full after inpatient hospital copay Outpatient: \$20 copay/visit
Mental Health Inpatient Outpatient	\$250 copay per admission \$20 copay
Other Services Ambulance Hospice care Home health care Durable medical equipment	\$100 copay Covered in full, unlimited days \$35 copay/specialist visit up to 40 visits/year (\$20 copay/PCP visit) Covered at 50% (no annual dollar limit)
Emergency room In-area/contract facility In-area/noncontract facility Out-of-area/noncontract facility	\$150 copay/visit; waived if admitted; urgent care: \$35 copay/visit \$150 copay/visit; waived if admitted \$150 copay/visit; waived if admitted
Prescription Drug Coverage (excluding dental prescriptions) Retail (generic; 30-day supply) Retail (brand; 30-day supply) Mail order (90-day supply)	Open Formulary, however some medications require preauthorization or step therapy, regardless of tier \$10 copay Formulary brand: \$50 copay; Nonformulary brand: \$100 copay \$25 copay generic; Formulary brand: \$125 copay; Nonformulary brand: \$250 copay