Independent Health

Account Name: Trustees:Erie County Bar Association
Account #: 24638
Sales Representative: Tracy D'Agostino
Plan Effective Date: January 1, 2019

Benefit Summary

Plan Name:	Medicare Passport		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$0	$250	
Out-of-Pocket Maximum	$3,400	$5,100 combined OOP max for in and out of network.	
Preventive Services			
Abdominal Aortic Aneurysm Screen Annual Physical Exam Basic Metabolism Test Bone Mass Measurement Cholesterol Test (Lipid Panel) Colonoscopy and Sigmoidoscopy Fecal Blood Testing Flu Shot Hemoglobin and Hematocrit Testing Hepatitis B Vaccine HIV screening HPV screening Mammogram Pap Smear Pneumonia Vaccine Prenatal and Post-partum Visits Prostate Exam (Prostate Specific Antigen "PSA") Rh Screening Rubella screening	Covered in full	Deductible and 20% coinsurance	All preventive services are covered in full with $0 member liability when performed by a Medicare participating provider. See independenthealth.com for additional information. Additional tests and screenings may require a copay. See your EOC, chapter 4.
Physician and Other Services			
Primary Care Physician	$5 copayment	$30 copayment	
Specialty Physician	$20 copayment	$30 copayment	
Outpatient Surgery (PCP's office)	$5 copayment	$30 copayment	
Outpatient Surgery (Specialist's office)	$20 copayment	$30 copayment	
Telemedicine Program	$20 copayment	Not Covered	Administered by Teladoc
Emergency & Urgent Care Services			
Emergency Room	$50 copay Waived if admitted to hospital	$50 copay Waived if admitted to hospital	
Ambulance	$50 copayment	$50 copayment	
Urgent Care - After Hours Facility	$20 copayment	Not Applicable	
Urgent Care - Out of Area Nationwide	Not Applicable	$30 copayment	

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Hospital and Other Facility Services			
Inpatient Hospital	$100 copayment Maximum one copayment per calendar year	Deductible and 20% coinsurance	
Outpatient Surgical Procedures (Hospital Facility)	$50 copayment	Deductible and 20% coinsurance	
Skilled Nursing Facility	$250 copayment for up to 100 days per benefit period	Deductible and 20% coinsurance up to 100 days per benefit period	
Diagnostic Testing Services			
Lab Services	Covered in full	Deductible and 20% coinsurance	
X-Rays	$20 copayment	Deductible and 20% coinsurance	
Advanced Radiology	$20 copayment	Deductible and 20% coinsurance	
Diagnostic Tests	$5 Copay - PCP $20 Copay - SCP	Deductible and 20% coinsurance	
Radiation Therapy	$20 copayment	Deductible and 20% coinsurance	
Mental Health & Substance Abuse			
Inpatient Mental Health	$100 copayment Maximum one copayment per calendar year	Deductible and 45% coinsurance	190 day lifetime limit
Outpatient Mental Health	$20 copayment	Deductible and 45% coinsurance	
Inpatient Substance Abuse - Rehab	$100 copayment 1 max per year	Deductible and 20% coinsurance	
Outpatient Substance Abuse	$20 copayment	Deductible and 45% coinsurance	
Rehabilitation Services			
Chiropractic - Medicare Covered	$20 copayment	50% coinsurance	
Physical - Occupational - Speech Therapies	$15 copayment	$25 copayment	
Cardiac Rehabilitation	Covered in full	$25 copayment	
Pulmonary Rehabilitation	Covered in full	$25 copayment	

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Additional Services			
Durable Medical Equipment	20% coinsurance	Deductible and 40% coinsurance	
Prosthetic Devices	20% coinsurance per item	Deductible and 20% coinsurance per item	
Home Health Care	Covered in full	Deductible and 20% coinsurance	
Healthy Benefits	$0 Activation Fee Annual Gym Membership	Not Covered	
Renal Dialysis	Covered in full	Covered in full	
Medicare Covered Podiatry Services	$20 copayment	$30 copayment	
Nutritional Therapy for ESRD or Diabetes	Covered in full	Deductible and 20% coinsurance	
Hearing Aids and Evaluation Exam	$45 Evaluation Exam $699/Ear Flyte Advanced $999/Ear Flyte Premier	Not Covered	48 Additional Batteries 3 Year Warranty Must use a TruHearing Provider
Prescription Drug Coverage			
Prescription Plan	$0/$0/$25/$40/$40 ICL $5000	$0/$0/$25/$40/$40 ICL $5000	Out Of Network Coverage is limited per situation. See your EOC, chapter 5.
Maintenance Medications	2.5 copays for 90 day supply through mail order or at select retail pharmacies	Not Covered	
Medicare Part D Creditable Coverage Status	Creditable	Not Applicable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare, therefore this plan provides you with CREDITABLE COVERAGE
Vision Services			
Medical Eye Exam	$20 copayment	$30 copayment	From an EyeMed provider
Routine/ Refractive Exam	Covered in full	$35 Reimbursement	From an EyeMed provider Includes Retinal Imaging
Eyewear - Routine - Annual Limit	Up to $150 annually	Up to $150 annually	From an EyeMed provider Combined in and out of network
Eyewear - Post Cataract Surgery	Covered in full	Covered in full	From an EyeMed provider
Dental Services			
Medicare Covered Dental Services (excludes Preventive and Comprehensive Dental Services)	Copayment is based on where the service is rendered	20% coinsurance	

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Medicare Part B Drugs			
Administered in Providers Office	20% coinsurance	Deductible and 20% coinsurance	
Used with DME	20% coinsurance	Deductible and 20% coinsurance	
Self Administered - Hemophilia	20% coinsurance	Deductible and 20% coinsurance	
Post Transplant Immunosuppressive	20% coinsurance	Deductible and 20% coinsurance	
Injectable Osteoporosis Drugs	20% coinsurance	Deductible and 20% coinsurance	
Antigens	20% coinsurance	Deductible and 20% coinsurance	
Certain Oral Cancer/Anti-nausea	20% coinsurance	Deductible and 20% coinsurance	
Drugs for Home Dialysis	20% coinsurance	Deductible and 20% coinsurance	
Interveneous Immune Globulin	20% coinsurance	Deductible and 20% coinsurance	

Important Notes

If PCP has a secondary specialty other than Internal Med, Gen Practice, Family Practice, Pediatrics, Geriatrics or Obstetrics/Gynecology, the specialty copay applies.

Your prescription drug benefit has a coverage gap. Your plan does not have a prescription drug deductible. When the total drug cost paid by you and Independent Health - combined - reaches $5,000 for the year, the coverage gap begins.

The Affordable Care Act has a provision that reduces your liability for the cost of Medicare covered Part D drugs in the coverage gap. In 2019, your liability for the cost of Medicare covered Part D brand drugs in the coverage gap is 25% of the cost of the drug. Your liability for the cost of Medicare covered Part D generic drugs in the coverage gap is 37% of the cost of the drug or the cost sharing amount based on the drugs' tier, whichever is lower. The lower copay will be applied at the point of sale.

If you have a Medicare Part D Low Income Subsidy rider, the terms and conditions of the Low Income Subsidy rider will supersede the terms and conditions of the drug rider attached to this contract, where applicable.

The coverage gap ends when you have spent $5,100 OUT OF YOUR POCKET. When the coverage gap ends, the catastrophic coverage stage begins and lasts until the end of the calendar year. At the catastrophic stage, your copayment will be $3.40 for generic drugs, $8.50 for brand drugs or 5%, whichever is greater.

Please refer to the Independent Health Prescription Drug Formulary and Evidence of Coverage document for more details.

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 detailed information, consult your Group Health Contract, attached Riders (if any), or Evidence of Coverage.