This grid provides an overview of the Self-funded Services benefits selected by the Group listed below. It should only be used as a guide. For a complete listing of the Plan benefits and their specific provisions refer to the Group's Summary Plan Description.

Plan Name:	North Tonawanda City School District Encompass B 2015	
Group Name:	North Tonawanda City School District	
Group Nos. and Benefit Package/ Plan(s):	**Group Number(s) & Corresponding Benefit Package/Plan(s):** 22891 RX copays $10/20/35 **Grandfathered Plan?** No	
Group Addresses:	**Local Address:** North Tonawanda City School District 176 Walck Rd N. Tonawanda, NY 14120	**Corporate Address:**
Group Contact Information: ***(Contact Names & Titles, Addresses, Phone Nos., Fax Nos., Email Addresses)***	Laurie Burger Director of Personnel 807-3514 807-3522 FAX lburger@ntschools.org	
Original Plan Effective Date:	May 1, 2009	**Plan Amendment Date(s):** 7/1/10 MH parity 7/1/11 • Age 26 ROS • Alc/SA and MH limits removed • Preventive services revised • EyeMed Insight network • First Health as wrap network 7/1/12 – No benefit changes, IH to coordinate External appeals 11/1/12 Preventive list to include Nutritional counseling & diabetic teaching 7/1/13 Women's wellness 1/1/14 • New benefit package NT06 • Benefits based on calendar year IN OOP max $2,000/$4,000 includes copay/deductibe/coninsurance • OON OOP max includes deductible/coinsurance

		• Remove $1,000 DME limit in network only • Clinical trials- covered based on ACA guidelines • Smoking Cessation language updated • PKU $2,500 limit removed • Effective 07/01/2014: Mirena and Implanon no longer need to be obtained thru a specialty pharmacy. 1/1/15 • Residential Treatment on SA/MH Pharmacy IN OOP Max Single $4,600/Family $9,200 not shared with medical
Other Contact Information:	**Admin Billing:** Laurie Burger	**Claims Funding:** Laurie Burger
	Authorized Access to PHI: Laurie Burger, Pat Divigilio , Priscilla Koser, Jennifer Heiler, Premier Consulting.	**Out of Plan Payment Authorization:** Laurie Burger
	Client Service Rep: Barb Folckemer	**Sales Account Manager:** Nancy Porter
Broker Contact Information ***(Contact Names & Titles, Addresses, Phone Nos., Fax Nos., Email Addresses)***	Premier Consulting	
Tier Type:	**1** | **2** | **3** | **4** | **Other**	
Plan Design Based on :	2009 Encompass B w/POS (mirror of 31329H)	

Who is Eligible for this Plan?	Retiress Under Age 65
Eligibility and Termination Provisions	Effective date: lst of month following DOH Termination date: End of month following termination
Dependent Coverage Age Limitations	UP TO AGE 26 UNTIL END OF BIRTHDAY MONTH
Open Enrollment Period	MONTH: November
Enrollment Transmission Format	Paper

	In-Network	Out-of-Network
Deductible	Not applicable.	$250 per Individual. $500 per Family Unit.
Coinsurance	Not applicable unless otherwise noted.	Plan pays 80% Coinsurance/Covered Person pays 20% Coinsurance. (Durable Medical Equipment, Prosthetics & Appliances: 50%.)
Annual Maximum	Not applicable.	Not applicable.
Lifetime Maximum	Not applicable.	Not applicable.
Out-of-Pocket Maximum	$2,000 per Individual. $4,000 per Family Unit. **Copay/Deductible/Coinsurance:** apply towards Out-of-Pocket Maximum. . Pharmacy OOP max single $4,600/Family $9,200 not shared with medical	$2,000 per Individual. $4,000 per Family Unit. **Deductible: DOES** apply towards Out-of-Pocket Maximum. **Coinsurance: DOES** apply towards Out-of-Pocket Maximum. **Note**: Once this is met, the Covered Person will not be responsible for Deductible or coinsurance; balance billing may still apply.
Usual, Customary and Reasonable Rate (UCR)	Not applicable.	90th Percentile. Covered Persons may be balance billed for the difference between UCR and billed charges even if the Out-of-Pocket Maximum has been met. If UCR rate is not available and Independent Health cannot negotiate a rate, billed charges apply.
Pre-certification Penalty (*for Failure to Pre-Certify Specific Services*)	Not applicable.	The Plan will pay only 50% of the lesser of the Medically Necessary Non-participating Provider's charges, negotiated rate or UCR (Usual, Customary and Reasonable) rate to the 90th percentile for services. The Covered Person pays the balance, if any. The additional percentage is a penalty, and does not apply to the Out-of-Pocket Maximum, Deductible or Coinsurance limit.
Preventive Services ***SC= Service Class**	**Covered in full** Preventive Services Grid If a sick office visit (E & M) is billed, member liability is applied. NOTE: Blood collection codes 36415 and 36416 (in-network only). • Preventive laboratory service only: Covered in full. • Combined preventive lab service with non-preventive lab service: Covered in full. • Non-preventive lab service: Covered in full.	Not applicable.
Provider Network	IHC	Not applicable. **Note**: If the servicing Physician/Provider is **outside of the eight counties of WNY** and is in the First health network, the Covered Person is only responsible for the applicable Out-of-Network Covered Person liability (Deductible/Coinsurance). IH will pay the First Health fee

		schedule and the Covered Person will not be balanced billed the difference between the billed charges and First Health fee schedule. **Note**: If the servicing Physician/Provider is **in the eight counties of WNY** and is in the First Health network, the Covered Person is responsible for their applicable Out-of-Network Covered Person liability (Deductible/Coinsurance) and balanced billing may apply. Per the First Health contract, their fee schedule can not be applied.
Appeals	1st Level: Independent Health 2nd Level: Independent Health 3rd Level/External: Independent Health ($500 annual charge, IRO pass through fee with a 15% admin fee	
Line of Business Code		
No Control Clause	Claims process as an in-network benefit when rendered by a non-participating/non-network provider for **anesthesiology services** performed as an inpatient (place of service 21), outpatient (place of service 22) or ambulatory setting (place of service 24) and non-participating/non-network **physician inpatient services** (place of service 21) at a participating/network hospital or participating/network free standing ambulatory surgery facility setting.	
Primary Care Physician/Provider (PCP)	Required to be on file.	
Pre-existing Condition	Not applicable.	
PLAN NOTES AND UPDATES		
Medical Administrator	Independent Health	
Vision Administrator	EyeMed Insight Network	
Prescription Administrator	Independent Health's Pharmacy Benefit Dimensions	
Mental Health/Substance Abuse Administrator	Independent Health	
Dental Administrator	N/A	
COBRA Administrator	N. Tonawanda CSD	
FSA/HRA Administrator	None	
NOTES		

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
		Referral*	Provider Pre-Auth	Member Pre-Cert		Referral*	Provider Pre-Auth	Member Pre-Cert	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Acupuncture	Not covered.	N/A	N/A	N/A	Not covered	N/A	N/A	N/A	
Alcohol/Substance Abuse (Acute Conditions Only)									
Inpatient Facility Detox Only	Covered in full	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission does NOT apply.**	N/A	N/A	Y	
Inpatient Rehabilitation (Facility and physician)	Covered in full.	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Rapid readmission does NOT apply**	N/A	N/A	Y	
Residential Treatment ***Intensive Residential Rehabilitation Services are Reisdential Services*** *requiring 24/7 treatment in a structured environment.* ***Note:*** *Community Residential Services and Supportive Living Services are* ***NOT*** *covered.*	Covered in full	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission does NOT apply.**	N/A	N/A	Y	
Outpatient	$10 copayment per visit.	N/A	**N**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Family Therapy	$10 copayment per visit.	N/A	**N**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Allergy									
Allergy Testing	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
					payments may apply.				
Treatment (injections)	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Allergy Serum	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Rast Testing	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Ambulance	$50 copayment when medically necessary, including pre-hospital emergency services for treat and release. Wheelchair van transportation is not covered.	N/A	**Y** Planned Trans. N Emerg.	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	
Anesthesia									
Inpatient	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Outpatient	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Pain Management	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Artificial Insemination	Refer to infertility								
Assistant Surgeon									
Inpatient	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
					payments may apply.				
Outpatient	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Autologous Blood	20% copayment	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Cardiac Rehabilitation	Covered following a heart transplant, CHF, bypass surgery or a myocardial infarction, for up to 36 visits **per event** with a $10 copayment per visit. In-network plus out-of-network services combined equals the total benefit.	N/A	N	N/A	Covered following a heart transplant, CHF, bypass surgery or a myocardial infarction, for up to 36 visits **per event**, subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit. In-network plus out-of-network services combined equals the total benefit.	N/A	N/A	N	
Chemotherapy Treatment (Cancer)	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Chiropractic Care	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Clinical Trials	Based on ACA guidelines, see SPD amendment				Not covered				

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Contraceptive Devices (e.g. IUD, Diaphragm) – Includes insertion & removal	**Devices** dispensed in the office covered in full as a Medical benefit. For insertion, removal or fitting of device, Plan pays 100% after: If an office visit is required for the management of a new or ongoing condition and an injection is given in conjunction with that visit, then: $10 copayment Prior to 07/01/2014: Mirena - must be obtained through a Specialty Pharmacy, covered in full. Implanon – must be obtained through a Specialty Pharmacy, covered in full. The specialty pharmacy dispensing program for these devices is no longer mandatory.	N/A	N	N/A	Devices/injections dispensed in the office - covered as a medical benefit subject to deductible and coinsurance up to eligible expenses and additional payments may apply. For insertion, removal, fitting of device – subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Contraceptive Injectables (e.g. Depo Provera)	Effective 07/01/2014: Injections administered in the office: Plan pays 100% If an office visit is required for the management of a new or ongoing condition and an injection is given in conjunction with that visit, then $10 copayment	N/A	N	N/A	Devices/injections dispensed in the office - covered as a medical benefit subject to deductible and coinsurance up to eligible expenses and additional payments may apply. For insertion, removal, fitting of device – subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Contraceptives self-administered/used by the member: • **Cervical Cap** • **Diaphragm** • **NuvaRing®** • **OrthoEvra®** • **Oral Contraceptives (as listed in the formulary)** • **Female condoms** • **Spermicide**	Covered in full. Generic drugs/supplies with a physician's prescription. Brand-name drugs/supplies without a generic equivalent with a physician's prescription OTC drugs/supplies with a physician's prescription. Exception: Emergency contraceptives DO NOT require a physician's prescription	N/A	N	N/A	Covered Rx benefit through a participating pharmacy including the national pharmacy network. Applicable Rx copayment applies.	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	Refer to Prescription Drug Benefits. EXCEPTION: Tier 3 brand name drugs/supplies with generic available will be subject to Member Liability								
Cosmetic Surgery	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Applicable copayments based on services rendered.**	N/A	Y	N/A	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.**	N/A	N/A	Y Failure to pre-certify will result in denial to the member.	
Dental	Not covered.	N/A	N/A	N/A	Not Covered	N/A	N/A	N/A	
Accidental Dental	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within twelve months of the accident. **Applicable copayments**	N/A	**Y** Required after the initial exam and x-rays.	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	based on services rendered.								
Congenital Disease and Anomaly	Applicable copayments based on services rendered when deemed medically necessary.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply when deemed medically necessary.	N/A	N/A	**Y**	
Diabetic									
Diabetic Equipment (e.g. Blood Glucose Monitor, Glucowatch)	$10 copayment.	N/A	**Y** SC: 631 **N** SC: 685	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Diabetic Equipment Insulin Pump	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Diabetic shoes and inserts	Not covered	N/A	N/A	N/A	Not covered	N/A	N/A	N/A	
Diabetic Supplies	Up to a 30 day supply, $10 copayment per item.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Diabetic Teaching	Covered in full under Preventive Services	N/A	**Y** See QM Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Insulin, Oral Agents	Up to a 30-day supply, $10 copayment or Rx copayment, whichever is less.	N/A	N	N/A	Covered as a medical benefit: **Non-participating pharmacy:** subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Participating pharmacy:** covered as an in-network benefit.	N/A	N/A	**Y** see formulary	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Diagnostic Testing - (e.g. EKG, Stress Tests, **not** Lab or X-rays)	$10 copayment. **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Dialysis									
Outpatient Facility	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Outpatient Physician	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Durable Medical Equipment (DME)	Covered with a 20% copayment	N/A	**Y** SC 610/613 N SC 608	N/A	Subject to a deductible and 50% coinsurance up to eligible expenses and additional payments may apply. Limit: up to an annual maximum of $1,000 per member per contract year.	N/A	N/A	**Y** Refer to Member pre-cert policy	
ECT	See Mental Health								
Emergency Care									
Emergency Room Facility *also see Urgent Care*	$50 copayment at any hospital worldwide; copayment waived if admitted.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	
ER Physician	Covered in full.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
ER Follow Up Visit	Office visit or emergency room copay may apply.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	
Observation Beds - Facility	$50 copayment at any hospital worldwide; copayment waived if admitted. If ER copayment & Observation Facility copayment billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	
Observation Beds – Physician	Covered in full.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A	N/A	
Hearing									
Hearing Tests	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments	N/A	N/A	N	
Evaluation and Fitting for Hearing Aids	Not covered.	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Hearing Aids	Not covered.	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Home Health Care / Aide **1 Home Health Aide visit = up to 4 continuous hours**	$10 copayment per visit for up to 40 visits per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	**Y** Required before the first visit.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 40 visits per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	N/A	**Y** Required before the first visit.	
Private Duty Nursing	Not covered.	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Home Infusion									

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Therapy (for Enteral and Parenteral, see Nutritional Supplies)									
Nursing Services/Visits	Covered in full with no visit limitation.	N/A	**Y** See MRM Home Infusion Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no visit limitation.	N/A	N/A	**Y** Required before the first visit.	
Medication	Covered in full.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no visit limitation.	N/A	N/A	**Y** Required before the first visit.	
Other Services (e.g. supplies and per diem items)	Covered in full.	N/A	**N**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no visit limitation.	N/A	N/A	**Y** Required before the first visit.	
Home Visit (other than Home Health Care or Home Infusion Therapy)	$10 copayment with no limitation.	N/A	**N**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no visit limitation.	N/A	N/A	**N**	
Hospice *(includes Bereavement Counseling)*									
Advance Care Planning (this benefit includes the Caring Hearts Perinatal Program)	Covered in full for up to 6 visits per contract year for pre-hospice services. In-network plus out-of-network services combined equals the total benefit.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 6 visits per contract year for pre-hospice services. In-network plus out-of-network services combined equals the total benefit.	N/A	N/A	N	
Inpatient	Covered in full with no day limitations. Hospice services shall include both	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission with no day limitations .	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	inpatient and outpatient services, as well as medically necessary supplies and drugs.				Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. In-network plus out-of-network services combined equals the total benefit. **Rapid readmission DOES NOT apply.**				
Outpatient (Home)	Covered in full no day limitations. Hospice service shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. In addition, family members are entitled to bereavement counseling.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit with no day limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. In addition, family members are entitled to bereavement counseling.	N/A	N/A	N	
Hospital – Inpatient	Covered in full	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Rapid readmission does NOT apply.**	N/A	N/A	Y	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Hospital – Inpatient Medical Rehab Facility	Covered in full for up to 45 days per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 45 days per contract year. In-network plus out-of-network services combined equals the total benefit. **Rapid readmission does NOT apply**	N/A	N/A	Y	
Immunizations									
Adult Immunizations (19 and over)	Covered in full. **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit, then a $10 office visit copayment would apply.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N/A	
Flu & Pneumonia Immunizations	Covered in full. **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit,**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N/A	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Hepatitis B Immunizations	Covered in full. **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit, then a $10 office visit copayment would apply.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N/A	
Travel Immunizations (19 and over)	Covered in full. **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit, then a $10 office visit copayment would apply.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N/A	
Child Immunizations (0-18 years) *AAP = American Academy of Pediatrics*	Covered in full up to the age of 19 according to ACIP guidelines if billed alone or with a well visit.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N/A	
Infertility	Coverage is pursuant to the eligibility requirements and conditions	N/A	**Y** RX	N/A	Coverage is pursuant to the eligibility requirements and conditions outlined by the Summary Plan	N/A	N/A	**Y** Rx - dispensed at a par pharmacy	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	outlined by the Summary Plan Description. **Applicable copayments based on services rendered.**				Description. **Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.** **Rx** MUST be obtained from a participating pharmacy.			and written by a non-par provider.	
Injections – Office-Based *(not self administered)*	$10 copayment.	N/A	**Y** Refer to Injectable Formulary for pre-auth require-ments	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Laboratory	Covered in full with a participating provider written order.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Mammograms									
Professional Services	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Technical Services	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Mastectomy / Post-Mastectomy									
Breast Prosthesis	Covered in full with no limitation.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no limitations.	N/A	N/A	N	
Post Mastectomy Supplies (Bras)	Covered in full with no limitation.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
					with no limitations.				
Reconstructive Surgery	**See Hospital and Outpatient Surgical Procedures**								
Maternity Care									
Prenatal & Postnatal Visits	Covered in full after initial diagnosis.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Breast Feeding /Lactation Support	Covered in full	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Sonogram(s)	$15 copayment.	N/A	N	N/A	Subject to deductible and coinsurance coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Delivery - Facility	Covered in full	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Rapid readmission DOES NOT apply.**	N/A	N/A	N	
Delivery - Physician	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Newborn	Covered in full	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Home Visit (Resulting from early discharge)	Covered in full	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Medical Supplies	Covered in full.	N/A	See fee schedule	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	Y	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Medical Expendable Supplies (in conjunction w/HHC)	Covered in full only when in conjunction with authorized skilled nursing services in the home.	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply only when in conjunction with authorized skilled nursing services in the home.	N/A	N/A	Y	
Mental Health									
Electroconvulsive Therapy (ECT) Facility Outpatient (e.g. Shock Therapy) ***Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit***	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A		
Electroconvulsive Therapy (ECT) Physician Outpatient (e.g. Shock Therapy) ***Note: ECT therapy during inpatient admission, refer to Mental Health Physician section for benefit.***	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Outpatient	$10 copayment	N/A	**N**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply	N/A	N/A	**N**	
Inpatient Physician	Covered in full when in conjunction with a covered Mental Health inpatient admission.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply when in conjunction with a covered Mental Health inpatient admission.	N/A	N/A	N	
Inpatient Facility	Covered in full **Rapid readmission does NOT apply.**				Subject to deductible and coinsurance up to eligible expenses and	N/A	N/A	**Y**	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
		N/A	Y	N/A	additional payments may apply **Rapid readmission does NOT apply.**				
Partial Hospitalization	$10 copayment for each partial hospitalization day.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply	N/A	N/A	**Y**	
Residential Treatment ***Intensive Residential Rehabilitation Services are Reisdential Services*** *requiring 24/7 treatment in a structured environment.* ***Note:*** *Community Residential Services and Supportive Living Services are* ***NOT*** *covered.*	Covered in full	N/A	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission does NOT apply.**	N/A	N/A	Y	
Pharmacological (chemotherapy) Management *A brief interaction between a psychiatrist and a member for the primary purpose of reviewing medications and issuing a prescription with minimal psychotherapy*	$10 copayment	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply	N/A	N/A	N	
MRI & MRA	**Provider must contact NIA for pre-authorization on below radiology services.**								
Professional Services	Covered in full.	N/A	**Y** Outpatient non-emergent by ordering provider.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Technical Services	$15 copayment	N/A	**Y** Outpatient non-emergent by ordering provider. Effective	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
			8/1/09 through NIA. Prior to 8/1/09 through IH MRM.						
Nutritional Counseling	Covered in full under Preventive Services	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Nutritional Supplies									
Enteral & Parenteral Pumps	See DME.	N/A	N/A	N/A	See DME.	N/A	N/A	N/A	
Parenteral Nutritional Supplies	**If provided in conjunction with Home Infusion visit,** covered in full.	N/A	**Y** Home Infusion See MRM Parenteral / Enteral Policy	N/A	**If provided in conjunction with authorized Home Infusion visit**, Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	Y	
Enteral Formula & Supplies	**If provided in conjunction with Home Infusion visit,** covered in full. **If provided as a prescription,** applicable Rx copayment would apply.	N/A	**Y** Home Infusion See MRM Parenteral / Enteral Policy **Y** Rx	N/A	**If provided in conjunction with authorized Home Infusion visit,** subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **If provided as a prescription,** MUST be obtained from a participating pharmacy.	N/A	N/A	**Y** Home Infusion **Y** Rx (if covered and dispensed at a par pharmacy and written by a non-par provider.)	
PKU Food Supplements	Covered as a Pharmacy benefit	N/A	N	N/A	**Applicable Rx copayment would apply.**	N/A	N/A	N	
Occupational Therapy	$15 copayment per visit for up to 20 visits per contract year combined with PT and ST, including evaluation(s).	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 20 visits per contract year combined with PT and ST, including evaluation(s).	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	In-network plus out-of-network services combined equals the total benefit.				In-network plus out-of-network services combined equals the total benefit.				
Office / PCP	$10 copayment. **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Office / Specialists	$10 copayment. **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Orthotics	Not Covered.	N/a	N/A	N/A	Not covered.	N/A	N/A	N/A	
Ostomy Supplies	Covered with a 20% copayment with no annual maximum.	N/A	**Y** Refer to P&A Fee Schedule for listing of pre auth requirements	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	Y	
Outpatient Surgical Procedures									
Facility	$10 copayment. **Copayment does not apply if service is listed under preventive care on first page of grid.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	**Y** Service Classes 006, 010	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	See Preventive Services								
Physician - Facility Based	Covered in full.	N/A	**Effective 1/1/11** **Y** Service Classes 006 (except for cancer Diagnosis), 010, 057, 055 (except for codes 93530 thru 93533, 93451 thru 93464 - cardiac catheteriza-tions)	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Office Based	$10 copayment. **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services**	N/A	**Effective 1/1/11** **Y** Service Classes 010, 055 (except for codes 93530 thru 93533, 93451 thru 93464 - cardiac catheteriza-tions)	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	**Y** Service Class 010	
Pap Smear –Routine	**See Preventive Service List Grid or Office Visit benefit.** **Lab Test:** Covered in full.	N/A	N	N/A	**PCP/OB GYN:** Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Lab Test:** Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physical Therapy	$15 copayment per visit for up to 20 visits per contract year combined with OT and ST, including evaluation(s).	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 20 visits per contract year combined with OT and ST,	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	In-network and out-of-network services combined equals the total benefit.				including evaluation(s). **In-network plus out-of-network services combined equals the total benefit.**				
Physician Visit (Inpatient)	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Podiatry	• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.								
Facility - Outpatient	$10 copayment. See Reimbursement Policy.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Podiatrist – Facility Outpatient Based	Covered in full. See Reimbursement Policy.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Podiatrist – Office Based Surgical Procedures	$10 copayment. See Reimbursement Policy.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Podiatrist – Office Visit (E&M)	$10 copayment. See Reimbursement Policy.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Prescription Drugs (RX)	$10/$20/$35	N/A	N/A	N/A	Covered benefit when written by a non-participating physician must be filled at a participating pharmacy including National Pharmacy network. Applicable pharmacy copay applies.	N/A	N/A	N/A	
Prosthetics and Appliances (P&A)	Covered with a 20% copayment with no annual maximum.	N/A	**Y** Refer to P&A Fee Schedule for listing of pre auth	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	Y refer to pre-cert policy	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
			require-ments						
Pulmonary Rehab	$10 copayment per visit for up to 24 visits per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 24 visits per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	N/A	**Y**	
Radiation Therapy									
Professional Services	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Technical Services	$15 copayment per visit. When services are performed in a physician's office during an office visit, 2 copayments will apply.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Radiology (X-rays)									
Professional Services	Covered in full.	N/A	**Y** CT, PET Scans and Myocardial Nuclear Perfusion Imaging (see glossary): Outpatient, non-emergent by ordering provider. **NOTE:** See MRI/MRA for Pre-Auth requirements	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Technical Services	$15 copay per visit. When	N/A	**Y** CT, PET	N/A	Subject to deductible and coinsurance up to eligible	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	services are performed in a physician's office during an office visit, 2 copays will apply. **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services.**		Scans and Myocardial Nuclear Perfusion Imaging (see glossary): Outpatient, non-emergent by ordering provider. **NOTE:** See MRI/MRA for Pre-Auth requirements		expenses and additional payments may apply.				
Reversal of Elective Sterilization	Not covered.	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Routine Physicals *(19 years old & older)*	Covered in full. This applies to services rendered by a physician in an office setting **excluding:** procedures, injections, diagnostic services, laboratory and x-ray services, and any other service not billed as an evaluation and management code (E&M code). **See specific benefit for any additional services rendered.**	N/A	N	N/A	Not covered.	N/A	N/A	N/A	
Second Surgical Opinion	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Scopes	**e.g. colonoscopy, flexible sigmoidoscopy, esophagogastroduodenoscopy (EGD)**								
Facility – Outpatient	$10 copayment **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician – Facility Outpatient Based	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician – Office Based Scope Procedures	$10 copayment **Copayment does not apply if service is listed under preventive care on first page of grid.** **See Preventive Services.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Skilled Nursing Facility (Sub-acute)									
Facility	Covered in full for up to 45 days per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 45 days per contract year. In-network plus out-of-network services combined equals the total benefit. **Rapid readmission does NOT apply.**	N/A	N/A	**Y**	
Physician/Ancillary Visits	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Sleep Studies	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Smoking Cessation									
	Covered in full for telephonic support and NRT products through the NYS Quitline. See below for Chantix and Zyban coverage. The telephone number for the NYS Quitline is 1-866-NY-QUITS (1-866-697-8487). Telephonic Support with NRT: After an assessment with a Quitline Specialist, eligible members are sent a free starter supply of NRT from the NYS Smokers Quitline. Roswell's Inhale Life phone coach calls member approximately two weeks later. If the member and the coach determine that the NRT is working and the member enrolls in Independent Health's telephonic support program, an additional two weeks of NRT is mailed directly to the member's home. The member will receive a call from Roswell's Inhale Life phone coach. Member is eligible for up to a total of 8 weeks of NRT products. This program is provided at no additional cost for eligible members. NOTE: The member must engage in the telephonic support program in order to receive NRT coverage. **Chantix and Zyban are covered if the member has pharmacy coverage.** If the member is not successful and wants to attempt to quit again, they need to contact the NYS Quit line. Classes are available in lieu of coaching calls. For information on available classes, members should call the NYS Smoker's Quitline. **Roswell will bill Independent Health for coaching calls and additional NRT product dispensed outside of the NYS Quit line and these claims will process on Power as a medical claim.**				Not covered	N/A	N/A	N	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Speech Therapy	$15 copay per visit for up to 20 visits per contract year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 20 visits per contract year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	N/A	N/A	N	
Termination of Pregnancy									
Facility	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Facility Based	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Office Based	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
TMJ Treatment	Covered when medically necessary**. Applicable copayments based on services rendered.**	N/A	Y	N/A	Covered when medically necessary**. Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.**	N/A	N/A	Y	
Transplants									
Donor (donates the organ)	Claims need to be submitted to the donors insurance company. An EOB from the other insurance then needs to be submitted to IHA. North Tonawanda	N/A	**Y** If IHA member	N/A	Claims need to be submitted to the donor's insurance company. An EOB from the other insurance then needs to be submitted to IHA. North Tonawanda will reimburse for the donation charges under	N	N	**Y** If IHA member	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	will reimburse for the donation charges under the recipient's IHA ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid, IHA will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **Applicable copayments based on services rendered.**				the recipient's IHA ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid. IHA will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.**				
Recipient (receives the organ)	Recipient must be a member of IHA. **Applicable copayments based on services rendered.**	N/A	**Y** (Except for Corneal Transplants)	N/A	Recipient must be a member of IHA. **Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.**	N/A	N/A	**Y** (Except for Corneal Transplant)	
Tubal Ligation									
Facility	Covered in full	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Facility Based	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Urgent Care Facility	**If member receives urgent care in the emergency room, the ER copayment applies.**								

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
In-Area	If member receives urgent care in a participating physician's office or facility, $10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Out-of- Area	If the member calls 24-Hour Medical Help Line prior to services being rendered, the member is responsible for in-network copayments. The copayment applies per provider per date of service, whether or not the service would normally take a copayment in-network. (e.g. lab work takes an office visit copayment under this benefit). Reimbursement will be either the lesser of billed charges or at the 90th percentile of the usual, customary and reasonable rate (UCR) of the region where the member received care, minus the applicable copayment(s). Members are responsible for the difference between Independent Health's reimbursement and the	N/A	N/A	**Y** 24-Hour Medical Help Line	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply if the member fails to precertify. If member does precertify, see **in-network** benefit.	N/A	N/A	**Y** 24-Hour Medical Help Line	

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
	provider(s) billed charges, unless a participating PHCS provider.								
After Hours Care	If member receives urgent care in participating After Hours Care Center, $35 copayment. **Urgent Medical Services Tipsheet**	N/A	N	N/A	Not applicable. See urgent care out of area.	N/A	N/A	N	
Vasectomy									
Facility	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Facility Based	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Physician - Office Based	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Vision (Network: EyeMed Insight, 1-866-842-3348)	Eye Med Plan # 9799644								
Medical	$10 copayment.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A	N	
Optical Dispensing *Plastic lenses* *Frames*	Covered thru EyeMed Standard Plastic Lenses: Single: $50 Bifocal: $70 Trifocal: $ 105 Progressive: $ 65	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	See Preferred Plan Encompass B

FOR INTERNAL USE ONLY	In-Network	REQUIREMENTS			Out-of-Network	REQUIREMENTS			Notes, Limitations
Contact Lenses (in lieu of eyeglass lenses) *Laser Vision Correction*	off retail Contacts Lenses: Conventional: member pays 85% of retail price (materials only). Specialty lenses are not covered. **U.S. Laser Network** for Lasik or PRK 15% discount on standard fees **OR** 5% off promotional pricing								
Post Cataract Lenses	Covered through EyeMed.	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Routine/ Refractive	Covered through EyeMed. $10 copay	N/A	N/A	N/A	Not covered.	N/A	N/A	N/A	
Well Baby/Child Care *(0-18 years)* *AAP = American Academy of Pediatrics*	Covered in full up to age 19 according to AAP guidelines.	N/A	N	N/A	Not covered.	N/A	N/A	N/A	

North Tonawanda Enc B $10/20/35 22891 Benefit Grid 2015

Authorized Person's Name

Title

Authorized Person's Signature

Date

Authorized signature above represents that all benefits listed on this grid are correct and accurate to the best of the client's knowledge and will be the basis for Independent Health to begin system programming and prepare the group's Summary Plan Description.