Independent Health
SELF-FUNDED SERVICES

North Tonawanda Schools

Benefit Summary

Benefit Summary

	Bronze Plan		
	In-Network	Out-Network	Additional Information
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and sigmoidoscopy Contraceptive Drugs, Devices, and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal and one postpartum visit Prostate test (Prostate Specific Antigen "PSA") Well child visit Well Woman visit	$0	Not Covered	All preventive services are covered in full with $0 member liability when performed by a participating provider. See independenthealth.com for additional information.
Physician and Other Services			
Primary Office Visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Specialist Office Visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Allergy Testing & Treatment	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (in physician's office)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Emergency and Urgent Care Services			
Emergency Room	Deductible then 20% coinsurance	Deductible then 20% coinsurance	
Ambulance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Must be deemed medically necessary
Participating After Hours Care Centers	Deductible then 20% coinsurance	Deductible then 20% coinsurance	
Hospital Services			
Inpatient Hospital	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room per admission
Inpatient Hospital Physician/Surgeon Fees	Deductible then covered in full	Deductible then 40% coinsurance	
Inpatient Hospice	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (Facility)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Skilled Nursing Facility	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 60 days per calendar year
Diagnostic Testing Services			
Laboratory Testing	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
EKG	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Routine Radiology	Deductible then 20% coinsurance	Deductible then 40% coinsurance	

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Advanced Radiology	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Radiology services, other than x-rays, including but not limited to MRI, MRA, CT Scans, PET Scans.
Maternity Services			
Physician Services: Prenatal and Postnatal Care	Covered in full	Deductible then 40% coinsurance	No charge after the initial diagnosis
Inpatient Maternity	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room per admission
Mental Health and Substance Abuse			
Inpatient Mental Health	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room per admission
Outpatient Mental Health	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Inpatient Substance Abuse – Rehab	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room per admission
Inpatient Substance Abuse – Detox	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room per admission
Outpatient Substance Abuse	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Pharmacy member liability may apply.
Insulin and Other Oral Agents	Deductible then 20% coinsurance	Deductible then 40% coinsurance	30-day supply or pharmacy liability, whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Pharmacy member liability may apply.
Rehabilitation Services			
Chiropractic Services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Physical – Occupational – Speech Therapies	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 30 visits (combined) per plan year
Cardiac Rehabilitation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 24 visits per event
Pulmonary Rehabilitation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 24 visits per plan year
Additional Services			
Durable Medical Equipment (DME)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Prior authorization may be required.
Prosthetics and Appliances	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Prior authorization may be required.
Chemotherapy	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Home Health Care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 40 visits per plan year
Prescription Drug Coverage			
Prescription Plan	$15/50%/ 50% after deductible	Not Applicable	Must be filled at a participating pharmacy
Maintenance Medications	2.5 copays per 90 day supply	Not Applicable	Mail Order: Must be obtained from ProAct or

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			Wegmans Retail Pharmacy: Must be filled at a participating pharmacy
Vision Services			
Medical Eye Exam	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Routine/ Refractive Exam	Not covered	Not Covered	
Standard Plastic Lenses	Not covered	Not Covered	
Frames	Not covered	Not Covered	
Conventional Contact Lenses	Not covered	Not Covered	
Laser Vision Correction	Not covered	Not Covered	
Dental Services			
Preventive and Routine	Not covered	Not covered	
Accidental Dental	Based on services rendered	Based on services rendered	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month
General Information			
Deductible	$5,000 individual/$10,000 Family		
Coinsurance	20% after deductible	40% after deductible	
Out-of-Pocket Maximum	$6,350 single/$12,700 family	$10,000 single/$20,000 family	

Important Notes

Out-of-Network: Member is responsible for the difference between Independent Health's allowed amount and the non-participating provider's billed amount.

Pre-Certification: Certain services and benefits are subject to pre-certification. Member is responsible for reviewing their Summary Plan Description (SPD) for pre-certification requirements. Penalty for not pre-certifying: the member is responsible for the payment of 50% of the eligible expenses for each service. Additional payments may apply. This additional percentage is a PENALTY and does not apply to the out-of-pocket maximum, deductible, and coinsurance.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitation, and exclusions. For more detailed information consult your Summary Plan Description (SPD).

All indicated benefits assume the member has appropriate authorization to receive services.

To locate a participating provider, please visit www.independenthealth.com. It is recommended you call your provider’s office to verify participation prior to each visit.