Independent Health
SELF-FUNDED SERVICES

North Tonawanda Schools
Benefit Summary

Benefit Summary

	Encompass B		
	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	$10 copayment	Deductible then 20% coinsurance	
Specialist Office Visit	$10 copayment	Deductible then 20% coinsurance	
Allergy Testing & Treatment	$10 copayment	Deductible then 20% coinsurance	
Outpatient Surgical Procedures (in physician's office)	$10 copayment	Deductible then 20% coinsurance	
Emergency and Urgent Care Services			
Emergency Room	$50 copayment	$50 copayment	Waived if admitted
Ambulance	$50 copayment	$50 copayment	Must be deemed medically necessary
Participating After Hours Care Centers	$35 copayment	Deductible then 20% coinsurance	
Hospital Services			
Inpatient Hospital	Covered in full	Deductible then 20% coinsurance	Semi-private room per admission
Inpatient Hospital Physician/Surgeon Fees	Covered in full	Deductible then 20% coinsurance	
Inpatient Hospice	Covered in full	Deductible then 20% coinsurance	
Outpatient Surgical Procedures (Facility)	$10 copayment	Deductible then 20% coinsurance	
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	Covered in full	Deductible then 20% coinsurance	
Skilled Nursing Facility	Covered in full	Deductible then 20% coinsurance	Up to 45 days per calendar year
Diagnostic Testing Services			
Laboratory Testing	Covered in full	Deductible then 20% coinsurance	
EKG	$10 copayment	Deductible then 20% coinsurance	
Routine Radiology	$15 copayment	Deductible then 20% coinsurance	
Advanced Radiology	$15 copayment	Deductible then 20%	Radiology services, other

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		coinsurance	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 20% coinsurance	
Inpatient Maternity	Covered in full	Deductible then 20% coinsurance	
Mental Health and Substance Abuse			
Inpatient Mental Health	Covered in full	Deductible then 20% coinsurance	Semi-private room per admission
Outpatient Mental Health	$10 copayment	Deductible then 20% coinsurance	
Inpatient Substance Abuse – Rehab	Covered in full	Deductible then 20% coinsurance	Semi-private room per admission
Inpatient Substance Abuse – Detox	Covered in full	Deductible then 20% coinsurance	Semi-private room per admission
Outpatient Substance Abuse	$10 copayment	Deductible then 20% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc)	$10 copayment	Deductible then 20% coinsurance	Pharmacy member liability may apply.
Insulin and Other Oral Agents	$10 copayment	Deductible then 20% coinsurance	30-day supply or pharmcy liability, whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc)	$10 copayment	Deductible then 20% coinsurance	Pharmacy member liability may apply.
Rehabilitation Services			
Chiropractic Services	$10 copayment	Deductible then 20% coinsurance	
Physical – Occupational – Speech Therapies	$15 copayment	Deductible then 20% coinsurance	Up to 20 visits (combined) per plan year
Cardiac Rehabilitation	$10 copayment	Deductible then 20% coinsurance	Up to 36 visits per event
Pulmonary Rehabilitation	$10 copayment	Deductible then 20% coinsurance	Up to 24 visits per plan year
Additional Services			
Durable Medical Equipment (DME)	20% copayment	Deductible then 50% coinsurance	Prior authorization may be required.
Prosthetics and Appliances	20% copayment	Deductible then 50% coinsurance	Prior authorization may be required.
Chemotherapy	$10 copayment	Deductible then 20% coinsurance	
Home Health Care	$10 copayment	Deductible then 20% coinsurance	Up to 40 visits per plan year
Prescription Drug Coverage			
Prescription Plan	Based on Collective Bargaining Agreement	Must be obtained at a participating pharmacy including National Pharmacy Network.	Pharmacy member liability may apply.
Maintenance Medications	2.5 copays per 90 day	Not Applicable	Mail Order: Must be

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	supply		obtained from ProAct or Wegmans Retail Pharmacy: Must be filled at a participating pharmacy
Vision Services			
Medical Eye Exam	$10 copayment	Deductible then 20% coinsurance	
Routine/ Refractive Exam	$10 copayment	Not Applicable	Once every 12 months
Standard Plastic Lenses	Standard Plastic Lenses: Single: $50 Bifocal: $70	Not Applicable	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% of retail price	Not Applicable	
Conventional Contact Lenses	15% of retail price	Not Applicable	Materials only
Laser Vision Correction	15% discount	Not Applicable	Discount is based on retail pricing
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	N/A	$250 single/$500 family	
Coinsurance	N/A	20% after deductible (Durable Medical Equipment, Prosthetics & Appliances: 50%)	
Out-of-Pocket Maximum	$2,000 single/$4,000 family	$2,000 single/$4,000 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).

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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.