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:	22891-First Choice **BENEFITS BASED ON CALENDAR YEAR**				
Group Name:	North Tonawanda City School District				
Group Nos. and Benefit Package/ Plan(s):	**Group Number(s) & Corresponding Benefit Package/Plan(s):** **22891** **Grandfathered Plan - No**				
Group Addresses:	**Local Address:** 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:	1/1/2016				**Plan Amendment Date(s):**
Other Contact Information:	**Admin Billing:** Laurie Burger				**Claims Funding:** Laurie Burger
	Authorized to Access PHI: Laurie Burger, Pat Divigilio , Christine McClinsey, Kelly Lord Jennifer Heiler, Premier Consulting.				**Out of Plan Payment Authorization:** Laurie Burger
	Account Servicing Representative:				**Sales Account Manager:** Nancy Porter
Broker Contact Information ***(Contact Names & Titles, Addresses, Phone Nos., Fax Nos., Email Addresses)***	Kathy Almeter Premier Consulting Associates 716-688-5600				
Tier Type:	**1**	**2**	**3**	**4**	**Other**

Who has this plan?	Offered to all employees				
Options	**First Choice Tier 1**	**Specialty Services**	**Non First Choice Tier 2**	**Par Physician and Ancillary (IHC Network)**	**Out of Network**
Deductible			$500/$1000 The combined (Tier 2 and Out of Network) deductible applies to covered in network or out-of-network medical services (unless preventive) and does NOT apply to any applicable pharmacy coverage. On a Single policy, the individual combined deductible must be met before IH provides reimbursement for covered in-network or out-of-network services. On a Family policy, once a family member meets the individual combined deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family combined deductible before IH provides reimbursement for covered in-network or out-of-network services.	Not applicable on most benefits, see applicable benefit for coverage. If deductible is applicable then $$$$ are combined with Tier 2 and Out of Network services.	$500/$1000 The combined (Tier 2 and Out of Network) deductible applies to covered in network or out-of-network medical services (unless preventive) and does NOT apply to any applicable pharmacy coverage. On a Single policy, the individual combined deductible must be met before IH provides reimbursement for covered in-network or out-of-network services. On a Family policy, once a family member meets the individual combined deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family combined deductible before IH provides reimbursement for covered in-network or out-of-network services.
Coinsurance				20% DME, Ostomy, P&A 50%	

Out of Pocket	$2500 Individual $5000 Family (medical only) The combined deductible, copayment, coinsurance applies to the combined out-of-pocket max. On a Single policy, the individual combined out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network or out-of-network services. On a Family policy, once a family member meets the individual combined out-of-pocket max IH will provide 100% reimbursement of the allowed amount for covered in-network and out-of-network services, including pharmacy services. However, additional family members must satisfy the family combined out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered in-network or out-of-network services. Note: Once the combined out-of-pocket max is met, the member will not be responsible for any in-network or out-of-network deductible, copayments or coinsurance. Rx member liability applies separately to the Rx out-of-pocket maximum $4,100 Individual $8,200 Family		
Out-of-Plan Authorization Provision			Applicable
UCR	Not Applicable.		80th Percentile Members may be balance billed for the difference between UCR and billed charges. If UCR rate is not available and IH cannot negotiate a rate, billed charges apply. (Unless FIRST HEALTH – see below)
Penalty	In-Network N/A	Out of Network IH 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 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	Covered in full – in network Preventive Services Grid If a sick office visit (E & M) is billed, Covered Person 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: Subject to laboratory member liability.** • **Non-preventive lab service: Subject to laboratory member liability.**		Not applicable

Effective Date	1/1/2016
Plan Amendment Date	
Company	Self-Funded IHSFS
Dependent Coverage Age Limitations	Covered up to the end of the month of the dependent's 26th birthday
Guest Membership	Not Applicable
Primary Care Physician	Required to be on file. See specific benefit for provider pre-authorization requirements.
Pre-existing Condition	Not Applicable
Unique Services	Not Applicable
No Control Clause	No Control means Independent Health's process to follow industry standards for non-participating/non-network Anesthesia services and Non-participating/non-network Provider inpatient services to be covered as an In-Network benefit when services are obtained at a participating/network Hospital or participating/network free standing Ambulatory Surgery facility setting. Claims process as an in-network benefit when rendered by: a. Services provided by a Non-Participating anesthesiologist when the operating surgeon is a Participating Provider; b. Diagnostic laboratory and pathology tests referred to a Non-Participating laboratory or pathologist by a Participating Provider; or c. Consultation services by a Non-Participating Provider which are provided to you while you are confined as an inpatient at a Participating Hospital or other facility and the physician who requested the consultation is a Participating Provider.
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
Medical Administrator	**Independent Health**
Vision Administrator	**EyeMed**
Prescription Administrator	**Independent Health's Pharmacy Benefit Dimensions**
Mental Health/Substance Abuse Administrator	**Independent Health**
Dental Administrator	**N/A**
COBRA Administrator	**North Tonawanda City School District**
HSA Administrator	**N/A**

FSA/HRA Administrator	**N/A**				
Non Par Timely Filing	**1 year from DOS**				
Provider Network	**First Choice Providers** • Kenmore Mercy • Mercy Hospital • Sisters • St. Joseph • Mt. St. Mary's • Bertrand Chaffee • Buffalo Surgery Center (On Excelsior Campus) • Windsong Radiology • Center for Ambulatory Surgery • Southtowns Radiology • Buffalo Ambulatory Center • Seton Imaging • Effective 06.01.14 Eastern Niagara Hospitals (Lockport Memorial and Intercommunity Newfane Hospital) **List of Par CHS Facilities**	**Specialty Services** • Roswell (cancer treatment) • ECMC (Burns, Trauma, Transplants and MH/Sub Abuse) • Womens & Childrens Hospital (pediatric care) • Brylin (MH/Sub abuse)	**All other IHC par facilities** Some examples are: • Kaleida Hospitals • VNA Home Care	**Par IHC Physicians and Ancillary Providers** Some examples are: • Catholic Medical Partners • Buffalo Medical Group • Benson Surgical • Quest Diagnostics	Not Applicable **Note**: If the services provider is outside of the eight counties of WNY and is in the FIRST HEALTH network the member is only responsible for their applicable out-of-network member liability (deductible/coinsurance). IH will pay the FIRST HEALTH fee schedule and the member will not be balance billed the difference between the billed charges and FIRST HEALTH fee schedule. **Note**: If the servicing provider is in the eight counties of WNY and is in the FIRST HEALTH network the member is responsible for their applicable out-of-network member liability (deductible/coinsurance) and balance billing may apply. Per the FIRST HEALTH contract, their fee schedule cannot be applied.

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Acupuncture	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Alcohol/Substance Abuse (Acute Conditions Only)									
Inpatient Facility Detox Only	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance per admission. **Rapid readmission does NOT apply.**	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	**Y**
Inpatient Rehabilitation Facility	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance per admission. **If admitted through ER, covered in full.** **Rapid readmission does NOT apply.**	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	**Y**
Inpatient Rehabilitation Professional	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	Subject to deductible and 20% coinsurance.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Family Therapy	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	Subject to deductible and 20% coinsurance.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Residential Treatment ***Intensive Residential Rehabilitation Services*** *are Residential Services requiring 24/7 treatment in a structured environment.* ***Note****: Community Residential Services and Supportive Living Services are* ***NOT*** *covered.*	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance per admission. **If admitted through ER, covered in full.** **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission.	N/A	**Y**
Allergy Testing & Treatment	N/A	N/A	N/A	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Allergy Serum	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Rast Testing	Covered in full.	Covered in full	Subject to deductible and 20% coinsurance.	**If member goes to an Independent Lab:** **If collected in a doctor's office and is sent out or processed in doctor's office:**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Ambulance	N/A	N/A	N/A	$25 copayment when medically necessary. Wheelchair van transportation is not covered.	**Y** Planned Transportation N Emergency	N/A	Covered as an **in-network** benefit.	N/A	N/A
Anesthesia (Professional Services Only)									
Inpatient	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	N/A	N/A	N/A	Covered in full.	**Y** If dental procedure authorization is required to determine medical necessity for facility and anesthesiologist charges. If approved IH will pay for facility and anesthesiologist charges only. The dental surgeon's charges are the responsibility	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
					of the member or other insurance.				
Pain Management	See specific benefit based on where services were rendered.								
Artificial Insemination *Advanced Reproductive Treatment is not covered; this includes Gift, Zift, Etc.*	Member liability based on services rendered.	N/A	Member liability based on services rendered.	Member liability based on services rendered.	**Y** Rx N Artificial Insemination Treatment	N/A	Member liability based on services rendered. **Rx** MUST be obtained from a participating pharmacy.	N/A	N Artificial Insemination Treatment
Assistant Surgeon									
Inpatient	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Autism Mandate									
Assessment for Autism **(Diagnostic test to diagnose Autism)**	N/A	N/A	N/A	$20 copayment	N/A	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A
Applied Behavioral Analysis (ABA) (Applied Behavioral Analysis (ABA): is an intensive behavioral treatment program that attempts to improve the cognitive and social functioning of	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
children, primarily young children, with autism.) ABA Assessment for Autism									
ABA Treatment	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A
Assistant Communication Devices (ACD) Assistive Communication Devices are communication devices and/or software prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or licensed psychologist. Note: Laptop computers, personal digital assistants, and iPads or other tablet devices are NOT considered dedicated ACD's and, there, are not covered under this mandate.	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A
Autologous Blood	Covered in full.	Covered in full	Subject to deductible and 20% coinsurance.	Subject to 20% coinsurance.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Cardiac Rehabilitation	Covered in full following cardiac surgery, CHF or a myocardial	N/A	Subject to the deductible and 20% coinsurance following cardiac	$20 copayment following cardiac surgery, CHF or a myocardial	N	N/A	Covered following cardiac surgery, CHF or a myocardial infarction, 36 per **event.**	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	infarction, for up to 36 visits per **event.** In-network plus out-of-network services combined equals the total benefit.		surgery, CHF or a myocardial infarction for up to 36 per **event.** In-network plus out-of-network services combined equals the total benefit.	infarction, for up to 36 per **event.** In-network plus out-of-network services combined equals the total benefit.			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.		
Chemotherapy Treatment (Cancer)	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance.	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Chiropractic Care ***Maintenance Care not covered***	N/A	N/A	N/A	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A
Clinical Trials	Refer to SPD	Refer to SPD	Refer to SPD	Refer to SPD	Y	N/A	Refer to SPD	N/A	Y
Contraceptives administered in the provider's office: **Effective 07/01/2014: The specialty pharmacy dispensing program for these devices (Mirena & Nexplanon) is no longer mandatory.**	N/A	N/A	N/A	**Devices** dispensed in the office covered in full as a medical benefit. For insertion, removal or fitting of device, covered in full. Any covered contraceptive device should be	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				purchased and billed by the ordering provider and submitted to IH for reimbursement. **Injections** (Depo Provera) administered in the office covered in full. **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 the office visit member liability will apply.**					
Contraceptives self-administered/used by the member. • **Cervical Cap** • **Diaphragm** • **NuvaRing®** • **OrthoEvra®** • **Oral Contraceptives** • **Female condoms** • **Spermacide**	N/A	N/A	N/A	Covered in full. Prescription coverage is **NOT** required and claims will process in RX Claim. • Generic drugs/supplies with a physician's prescription • Brand-name drugs/supplies without a generic equivalent with a	**Y** See Formulary	N/A	**Not Covered.** See **in network** benefit	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				physician's prescription • OTC drugs/supplies with a physician's prescription. • **Exception:** Emergency contraceptives **DO NOT** require a physician's prescription **EXCEPTION: Tier 3 brand name drugs/supplies with generic available will be subject to Member Liability under Rx coverage. If no Rx coverage, Tier 3 brand name drugs/supplies with generic available will be NOT covered.**					
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	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma,	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma,	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other	**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.	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	diseases of the involved body part. **Member liability based on services rendered.**	infection or other diseases of the involved body part. **Member liability based on services rendered.**	infection or other diseases of the involved body part. **Member liability based on services rendered.**	diseases of the involved body part. **Member liability based on services rendered.**			**Member liability based on services rendered.**		
Dental (Preventive and Routine)	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Accidental Dental	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	**Y** Required after the emergency exam and x-rays.	N/A	Covered as an **in-network** benefit.	N/A	N/A
Congenital Disease and Anomaly	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	**Y**	N/A	Member liability based on services rendered when deemed medically necessary.	N/A	**Y**
Diabetic									
Diabetic Equipment (e.g. Blood Glucose Monitor)	N/A	N/A	N/A	Covered in full	**Y** See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Equipment Insulin Pump	N/A	N/A	N/A	Covered in full	**Y** See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Supplies	N/A	N/A	N/A	Covered in full	N	N/A	Subject to deductible and coinsurance up to	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							eligible expenses and additional payments may apply.		
Diabetic Teaching	Covered in full	Covered in full	Covered in full	Covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Shoes	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Insulin, Oral Agents	See Prescription Benefit	See Prescription Benefit	See Prescription Benefit	See Prescription Benefit	N	N/A	Must use a Participating Pharmacy.	N/A	**Y** See Formulary
Diagnostic Testing (e.g. EKG, Stress Tests, not Lab or X-rays)	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	$20 copayment. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 20% coinsurance **Member liability does not apply if service is listed on Preventive Services Grid.**	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Dialysis									
Outpatient Facility	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance.	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient Physician	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Durable Medical	N/A	N/A	N/A	50% coinsurance **Member liability**	**Y** See provider pre-auth grid	N/A	Subject to a deductible and 50% coinsurance up to eligible expenses	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Equipment (DME)				**does not apply if service is listed on Preventive Services Grid.**					
ECT	**See Mental Health.**	**See Mental Health.**	**See Mental Health.**	**See Mental Health.**	N/A	N/A	**See Mental Health.**	N/A	N/A
Emergency Care									
Emergency Room Facility - also see Urgent Care	$50 copayment. Copayment is waived if admitted.	$50 copayment. Copayment is waived if admitted.	$50 copayment. Copayment is waived if admitted.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A
ER Physician	Covered in full.	Covered in full.	Covered in full.	Covered in full.	N	N/A		N/A	N/A
ER Follow Up Visit	Office visit or emergency room Copayment may apply.	Office visit or emergency room Copayment may apply.	Office visit or emergency room Copayment may apply.	N/A	N	N/A		N/A	N/A
Observation Beds - Facility	$50 copayment at any hospital worldwide. If ER copayment & observation facility copayment are billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	$50 copayment at any hospital worldwide. If ER copayment & observation facility copayment are billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	$50 copayment at any hospital worldwide. If ER copayment & observation facility copayment are 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-networ**k benefit.	N/A	N/A
Observation Beds - Physician	N/A	N/A	N/A	Covered in full.	N	N/A	Covered as an **in-network** benefit.	N/A	N/A
Experimental/ Investigational	Refer to SPD	Refer to SPD	Refer to SPD	Refer to SPD	Y	N/A	Refer to SPD	N/A	Y
Hearing									

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Hearing Tests	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Evaluation and Fitting for Hearing Aids	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Hearing Aids .	Not covered ***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	Not covered ***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	Not covered ***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	Not covered ***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	N/A	N/A	Not covered ***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	N/A	N/A
Home Health Care/ Aide **1 Home Health Aide visit = up to 4 continuous hours.**	**Erie & Niagara County:** $20 copayment applies for up to 40 visits per contract year.	N/A	**Erie & Niagara County only:** Subject to deductible and 20% coinsurance. **All other WNY counties**: Covered in full. Applies for up to 40 visits per contract year.	$20 copayment applies for up to 40 visits per contract year.	**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 reduced by the number of in-network benefits.	N/A	**Y** Required before the first visit.

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Home Infusion Therapy (for Enteral and Parenteral, see Nutritional Supplies)									
Nursing Services/Visits	**Erie & Niagara County:** Covered in full	**N/A**	**Erie & Niagara County:** Subject to deductible and 20% coinsurance. **All other WNY counties**: Covered in full.	Covered in full.	**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	**Y** Required before the first visit.
Medication	**Erie & Niagara County:** Covered in full	**N/A**	**Erie & Niagara County:** Subject to deductible and 20% coinsurance. **All other WNY counties**: Covered in full.	Covered in full.	**Y** See Rx Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Required before the first visit.
Other Services (e.g. supplies and per diem items)	**Erie & Niagara County:** Covered in full	**N/A**	**Erie & Niagara County:** Subject to deductible and 20% coinsurance. **All other WNY counties**: Covered in full.	Covered in full.	**Y** See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Required before the first visit.
Home Visit (other than Home Health Care or Home Infusion Therapy)	N/A	N/A	N/A	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Hospice (includes Bereavement Counseling)									
Advance Care Planning	N/A	N/A	N/A	Covered in full for up to 6 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 6 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	N/A	N
Inpatient	N/A	N/A	N/A	Covered in full with no visit limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission with no day limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. **Rapid readmission does NOT apply.**	N/A	N
Outpatient (Home)	N/A	N/A	N/A	Covered in full with no visit limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may per visit with no visit limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							drugs. In addition, family members are entitled to bereavement counseling.		
Hospital - Inpatient (Room and Board)	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance **If admitted through ER,** covered in ful**l.** **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission unless admitted through the emergency room. **Rapid readmission does NOT apply.** **If admitted through ER,** Covered in full.	N/A	**Y**
Hospital - Inpatient - Medical Rehab Facility	Covered in full for up to 45 days per plan year. In-network plus out-of-network services combined equals the total benefit.	Covered in full for up to 45 days per plan year.	Subject to deductible and 20% coinsurance for up to 45 days per plan year. In-network plus out-of-network services combined equals the total benefit. **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission for up to 45 days per plan year. In-network plus out-of-network services combined equals the total benefit. **Rapid readmission does NOT apply.**	N/A	**Y**
Immunizations									
Adult Immunizations (19 and over) **Shingles vaccine ages 60 and over*	N/A	N/A	N/A	Covered in full **If an office visit is required for the management of a new or ongoing condition and an immunization is**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				given in conjunction with that visit, then office visit member liability will apply.					
Child Immunizations (0-18 years) *ACIP = Advisory Committee of Immunization Practices*	N/A	N/A	N/A	Covered in full up to the age of 19 according to ACIP guidelines if billed alone or with a well visit. **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 office visit member liability will apply.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Infertility *Advanced Reproductive Treatment is not covered.*	Member liability based on services rendered.	N/A	Member liability based on services rendered.	Member liability based on services rendered.	**Y** Rx N Infertility Treatment	N/A	Member liability based on services rendered. **Rx** MUST be obtained from a participating pharmacy.	N/A	**Y** Rx N Infertility Treatment
Injections – Office-Based *(not self administered)*	N/A	N/A	N/A	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:**	**Y** Refer to Injectable Formulary for pre-auth requirements.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				$20 copayment					
Laboratory & Pathology	Covered in full.	Covered in full.	Deductible and 20% coinsurance.	**If member goes to an Independent Lab:** Subject to deductible and 20% coinsurance. **If collected in a doctor's office and is sent out or processed in doctor's office:** Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mammograms									
Technical Services	Preventive: Covered in full. Diagnostic: Covered in full.	N/A	Preventive: Covered in full. Diagnostic: Deductible and 20% coinsurance.	Preventive: Covered in full. Diagnostic: $20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Professional Services	Preventive: Covered in full. Diagnostic: Covered in full.	N/A	Preventive: Covered in full. Diagnostic: Deductible and 20% coinsurance.	Preventive: Covered in full. Diagnostic: Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mastectomy Post-Mastectomy									
Breast Prosthesis	N/A	N/A	N/A	Covered in full with no limit. *(Women's Cancer Rights Act)*	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no limit. *(Women's Cancer Rights Act)*	N/A	N
Post Mastectomy	N/A	N/A	N/A	Covered in full with	N	N/A	Subject to deductible	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Supplies (Bras)				no limit. *(Women's Cancer Rights Act)*			and coinsurance with no limit up to eligible expenses and additional payments may apply. *(Women's Cancer Rights Act)*		
Reconstructive Surgery	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	N/A	N/A	**See Hospital and Outpatient Surgical Procedures**	N/A	N/A
Maternity Care									
Breast Feeding/Lactation Support *See home care benefit for nursing visits.*	Covered in full	Covered in full	Covered in full	Covered in full	N/A	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Prenatal & Postnatal Visits ***Note:** If a visit is unrelated to pregnancy member liability may apply based on services rendered.*	N/A	N/A	N/A	Covered in full after initial diagnosis.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Sonogram(s)	Covered in full.	N/A	Subject to deductible and 20% coinsurance	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Delivery- Facility	Covered in full.	Subject to deductible and 20% coinsurance.	Subject to deductible and 20% coinsurance	N/A	N	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
Delivery- Physician	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							and coinsurance up to eligible expenses and additional payments may apply.		
Newborn-Facility	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance.	N/A	N	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
Newborn-Physician	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Home Birth	N/A	N/A	N/A	Covered in full.	Y	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Home Visit (Resulting from early discharge)	Covered in full.	N/A	Subject to deductible and 20% coinsurance	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Medical Supplies	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance	Covered in full.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y**
Medical Expendable Supplies	**Erie & Niagara County only:** covered in full only when in conjunction with authorized skilled nursing services in the home.	N/A	**Erie & Niagara County only:** Subject to deductible and 20% coinsurance only when in conjunction with authorized skilled nursing services in the home.	Covered in full only when in conjunction with authorized skilled nursing services in the home.	**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	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
			All other WNY counties: Covered in full only when in conjunction with authorized skilled nursing services in the home						
Mental Health									
Electroconvulsive (ECT) Facility Outpatient (e.g. Shock Therapy) **Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit**.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	Subject to deductible and 20% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Electroconvulsive (ECT) Physician Outpatient (e.g. Shock Therapy) **Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit**	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mental Health Inpatient Facility	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance	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	**Y**
Mental Health Inpatient Physician	N/A	N/A	N/A	Covered in full.	**Y** Psychologist, CSW	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
					N Psychiatrist, Nurse Practitioner with a secondary specialty of psychiatry.		apply.		
Mental Health Outpatient	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment	Subject to deductible and 20% coinsurance.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mental Health Partial Hospitalization Care that is provided in lieu of inpatient mental health hospitalization at an approved facility.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	Subject to deductible and 20% coinsurance for each partial hospitalization day.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for each partial hospitalization day.	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	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment.	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment	Subject to deductible and 20% coinsurance	**Adult (19 years and over):** $15 copayment. **Child (0-18 years):** $0 Copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Residential Treatment Residential Treatment Intensive Residential	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Rehabilitation Services are Residential Services requiring 24/7 treatment in a structured environment. Note: Community Residential Services and Supportive Living Services are NOT covered.									
MRI & MRA	**See Radiology Services (Advanced)**								
Nutritional Counseling	Covered in full	Covered in full	Covered in full	Covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Nutritional Supplies									
Enteral & Parenteral Pumps	**See DME**	**See DME**	**See DME**	**See DME**	N/A	N/A	**See DME**	N/A	N/A
Parenteral Nutritional Supplies **<u>Parenteral Nutrition</u>** A feeding method in which nutrients go directly into the bloodstream through a catheter/IV placed into a vein, nutrition taken intravenously bypassed the digestive tract. You may also see terms TPN (total parenteral nutrition) or HA (hyperalimentation) used.	**Erie & Niagara County: If provided in conjunction with Home Infusion visit,** then see the Home Infusion benefit.	N/A	**Erie & Niagara County only: If provided in conjunction with Home Infusion visit**, then see the Home Infusion benefit. **All other WNY counties: if provided in conjunction with Home Infusion visit,** then see the Home Infusion benefit.	**If provided in conjunction with Home Infusion visit,** then see the Home Infusion benefit.	**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	**Y**
Enteral Formula & Supplies **<u>Enteral Nutrition</u>**	**Erie & Niagara County: If provided in conjunction with Home Infusion visit**,	N/A	**Erie & Niagara County only: If provided in conjunction with**	**If provided in conjunction with Home Infusion visit**, then see the Home	**Y** Home Infusion See MRM Parenteral /	N/A	**If provided in conjunction with authorized Home Infusion visit**, subject to	N/A	**Y** Rx (if written by a non-par provider)

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Giving supplemental nutrition through a special **feeding tube*** that enters directly into the stomach or small intestine. ***Feeding Tube** – placed directly into the stomach through an opening in the abdominal wall or inserted through the nose, the G-tube, J-tube, GJ-tube, NG-tube and/or extension tube through which formula, fluids and/or medication are given.	then see the Home Infusion benefit. **If provided as a prescription**, Rx member liability may apply.		**Home Infusion visit**, then see the Home Infusion benefit. **All other WNY counties: If provided in conjunction with Home Infusion visit,** then see the Home Infusion benefit. **If provided as a prescription,** Rx member liability may apply.	Infusion benefit. **If provided as a prescription**, Rx member liability may apply.	Enteral Policy **Y** Rx		deductible and coinsurance up to eligible expenses and additional payments may apply. **If provided as a prescription,** not covered at an out-of-network pharmacy.		N Home Infusion
PKU Food Supplements	N/A	N/A	N/A	Covered as a pharmacy benefit. **Rx member liability may apply.**	N	N/A	Covered as a pharmacy benefit. **Rx member liability may apply.**	N/A	N
Occupational Therapy	**See Therapies**								
Office Visits	N/A	N/A	N/A	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment **Member liability does not apply if service is listed on**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				Preventive Services Grid.					
Orthotics Custom molded shoe inserts.	N/A	N/A	N/A	Not covered.	N/A	N/A	Not covered.	N/A	N/A
Ostomy Supplies	N/A	N/A	N/A	Subject to 50% coinsurance.	N	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient Surgical Procedures									
Facility *Gastric Bypass is covered when medically necessary.*	$75 copayment. **Member liability does not apply if service is listed on Preventive Services Grid.**	$125 copayment. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 20% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	N/A	N **Y** If dental procedure authorization is required to determine medical necessity for facility and anesthesiologist charges. If approved IH will pay for facility and anesthesiologist charges only. The dental surgeon's charges are the responsibility of the member or other insurance.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Service Classes 006, 010
Physician - Facility Based	N/A	N/A	N/A	Covered in full.	**Y** See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							additional payments may apply.		
Physician - Office Based	N/A	N/A	N/A	**Adult (19 years and over:** **PCP:** $15 copayment **SCP:** $20 copayment. **Child (0-18 years):** **PCP:** $0 copayment **SCP:** $20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	**Y** See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Service Class 010
Eye Surgery Benefit	Facility: $75 copayment.	Facility: $125 copayment.	Facility: $125 copayment.	Surgeon: Covered in full.	N	N	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Other outpatient services not listed *(e.g. IV therapy, infusion, blood transfusions, etc.)*	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance**.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Pap Smear & HPV Testing	N/A	**Visit:** N/A **Lab test:** Covered in full	**Visit:** N/A **Lab test:** Covered in full	**Visit**: **See Preventive Service List Grid or Office Visit benefit.** Lab test: Covered in full	N	N/A	**Visit:** 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

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Physical Therapy	**See Therapies**								
Physician Visit (Inpatient)	N/A	N/A	N/A	**Visit:** Covered in full. **Surgery:** Covered in full.	N for visit Y See provider pre-auth grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatry									
Facility - Outpatient	$75 copayment.	$125 copayment**.**	Subject to deductible and 20% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Facility Outpatient Based	N/A	N/A	N/A	Covered in full.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Office Based Surgical Procedures	N/A	N/A	N/A	$20 copayment. See Reimbursement Policy.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Office Visit (E&M)	N/A	N/A	N/A	$20 copayment. See Reimbursement Policy.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Prescription Drugs (Rx)	N/A	N/A	N/A	Tier 1: $0 Tier 2: $25 Tier 3: $50 Covered through PBD. See IH Pharmacy Grid for coverage detail.	**Y**	N/A	MUST be obtained from a participating pharmacy even when written by a non-participating provider.	N/A	**Y** See Formulary
Prosthetics and Appliances (P&A) External only	N/A	N/A	N/A	Subject to 50% coinsurance.	**Y**	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Pulmonary Rehab	Covered in full for up to 24 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 24 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	Subject to deductible and 20% coinsurance for up to 24 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 24 visits per plan year. In-network plus out-of-network services combined equals the total benefit.	N	N/A	Subject to deductible and coinsurance for up to 24 visits per contract year. In-network plus out-of-network services combined equals the total benefit.	N/A	**Y**
Radiation Therapy									
Technical Services	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance.	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Professional Services	Covered in full.	Covered in full.	Subject to deductible and 20% coinsurance.	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Radiology (X-rays)									
Routine X-rays Technical Services	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	$20 copayment. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 20% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	$20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Routine X-rays Professional Services	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 20% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Advanced Radiology Technical Services	$20 copayment	$20 copayment.	Subject to deductible and	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Advanced Radiology Services includes: MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.	**Member liability does not apply if service is listed on Preventive Services Grid.**	**Member liability does not apply if service is listed on Preventive Services Grid.**	20% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	**Member liability does not apply if service is listed on Preventive Services Grid.**			eligible expenses and additional payments may apply.		
Advanced Radiology Professional Services	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 20% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Reversal of Elective Sterilization	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Routine Physicals (19 & older)	N/A	N/A	N/A	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	N/A	Not covered	N/A	N/A
Scopes	**e.g. colonoscopy, flexible sigmoidoscopy, esophagogastroduodenoscopy (EGD)**								
Facility – Outpatient	$75 copayment **Member liability**	$125 copayment. **Member liability**	**Subject to deductible and 20% coinsurance.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	does not apply if service is listed on Preventive Services Grid.	**does not apply if service is listed on Preventive Services Grid.**	**Member liability does not apply if service is listed on Preventive Services Grid.**				additional payments may apply.		
Physician – Facility Outpatient Based	N/A	N/A	N/A	Covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Office Based Scope Procedures	N/A	N/A	N/A	**Adult (19 years and over):** a $15/$20 Copayment. **Child (0-18 years):** $0/$20 Copayment. **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Skilled Nursing Facility (sub-acute)									

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Facility	Covered in full for up to 45 days per plan year. **Note:** Custodial care is not covered. **In-network plus out-of-network services combined equals the total benefit.**	Covered in full for up to 45 days per plan year. **Note:** Custodial care is not covered. **In-network plus out-of-network services combined equals the total benefit.**	Subject to deductible and 20% coinsurance for up to 45 days per plan year. **Note:** Custodial care is not covered. Rapid readmission does NOT apply. **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 plan year. Note: Custodial care is not covered. **Rapid readmission does NOT apply.** **In-network plus out-of-network services combined equals the total benefit.**	N/A	**Y**
Physician/Ancillary Visits	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Sleep Studies	Covered in full.	$20 copayment.	Subject to deductible and 20% coinsurance.	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	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.						Not Covered	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	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 as a medical claim.**								
Speech Therapy	**See Therapies**								
Termination of Pregnancy									
Facility	N/A	N/A	Subject to deductible and 20% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Facility Based	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician - Office Based	N/A	N/A	N/A	**Adult (19 years and over):** a $15/$20 Copayment. **Child (0-18 years):** $0/ $20 Copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Therapies-Outpatient **(Physical Therapy, Occupational Therapy**	**THERAPIES (see below)**								
Occupational Therapy	$20 copayment for up to 20 visits combined with PT and ST per plan year. In-network plus	$20 copayment for up to 20 visits combined with PT and ST per plan year. In-network plus	Subject to deductible and 20% coinsurance for up to 20 visits combined with PT and ST per plan year.	$20 copayment for up to 20 visits combined with PT and ST per plan year. In-network plus	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit for up to 20 visits per contract year combined with PT	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	out-of-network services combined equals the total benefit.	out-of-network services combined equals the total benefit.	In-network plus out-of-network services combined equals the total benefit.	out-of-network services combined equals the total benefit.			and ST, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.		
Physical Therapy	$20 copayment for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equals the total benefit.	Subject to deductible and 20% coinsurance for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equals the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up 20 visits per contract year combined with OT and ST, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	N/A	N
Speech Therapy	$20 copayment for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	Subject to deductible and 20% coinsurance for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	$20 copayment for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply 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	N/A
TMJ Treatment	Coverage based on services rendered	Coverage based on services rendered	Coverage based on services rendered	Coverage based on services rendered	N/A	Y	Coverage based on services rendered	N/A	Y
Transplants									
Donor (donates the organ)	N/A	Claims need to be submitted to the donor's insurance company. An EOB from the other	Claims need to be submitted to the donor's insurance company. An EOB from the other	Claims need to be submitted to the donor's insurance company. An EOB from the other	**Y** (If IH member)	N/A	Claims need to be submitted to the donor's insurance company. An EOB from the other insurance then needs to	N/A	**Y** (If IH member)

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
		insurance then needs to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid, IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	insurance then needs to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid, IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	insurance then needs to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid, IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**			be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid. IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**		
Recipient (receives the organ)	N/A	Recipient must be a member of IH. **If authorized, member liability based on services rendered.**	Recipient must be a member of IH. **If authorized, member liability based on services rendered.**	Recipient must be a member of IH. **If authorized, member liability based on services rendered.**	**Y** (Except for Corneal Transplants)	N/A	Recipient must be a member of IH. **If authorized, member liability based on services rendered.**	N/A	**Y** (Except for Corneal Transplant)
Tubal Ligation									
Facility	Covered in full.	N/A	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							apply.		
Physician – Facility Based	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Urgent Care									
In-Area	N/A	N/A	N/A	If member receives urgent care in a participating physician's office, subject to: **Adult (19 years and over):** a $15/$20 Copayment. **Child (0-18 years):** $0/$20 Copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Participating After Hours Care	N/A	N/A	N/A	$35 copayment.	N	N/A	Not Applicable. See urgent care out-of-area.	N/A	N/A
Out-of- Area	N/A	N/A	N/A	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Vasectomy									
Facility	N/A	N/A	Subject to deductible and 20% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician - Facility Based	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician - Office Based	N/A	N/A	N/A	**Adult (19 years and over):** a $15/$20	N	N/A	Subject to deductible and coinsurance up to	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				Copayment. **Child (0-18 years):** $0/$20 Copayment.			eligible expenses and additional payments may apply.		
Vision	**Enhanced Plan - 9863747**								
Medical	N/A	N/A	N/A	$20 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Optical Dispensing Routine/ Refractive Post Cataract Lenses	N/A	N/A	N/A	Covered through EyeMed	N/A	N/A	Not covered	N/A	N/A
Well Baby/Child Care *AAP = American Academy of Pediatrics*	N/A	N/A	N/A	Covered in full up to age 19 according to AAP guidelines.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

Plan Name: North Tonawanda Schools 22891- First Choice 2016

_____ _____

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 (if applicable).