# *Plan Document and Summary Plan Description for the North Tonawanda City School District Medical Plan*

- Medical and Prescription Drug Benefits

Effective Date: 01/01/2016

## Introduction

*North Tonawanda City School District (the "Employer" or "Company") is pleased to offer you this benefit plan. It is a valuable and important part of your overall compensation package.*

*This booklet describes your medical and prescription drug benefits and serves as the Summary Plan Description (SPD) and Plan document for the North Tonawanda City School District Medical Plan ("the Plan").*

*This document sets forth the provisions of the Plan that provide for payment or reimbursement of Plan benefits.*

*We encourage you to read this booklet and become familiar with your benefits. You may also wish to share this information with your enrolled family members.*

*This Plan and SPD replace all previous booklets you may have in your files. Be sure to keep this booklet in a safe and convenient place for future reference.*

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# Plan Overview

## Your Eligibility

You are eligible for benefits if you are:

- A full-time active employee normally scheduled to work a minimum of 30 hours per week;
- A part-time active employee normally scheduled to work a minimum of 30 hours per week;
- On the regular payroll of the Company; and
- In a class of employees eligible for coverage.

Unless otherwise communicated to you in writing by the Company, the following individuals are not eligible for benefits: employees of a temporary or staffing firm, payroll agency or leasing organization, independent contractors and other individuals who are not on the Company payroll, as determined by the Company, without regard to any court or agency decision determining common-law employment status.

## Eligible Dependents

You may enroll your eligible dependents on your coverage. Your eligible dependents include:

- your legal spouse;
- your child under age 26 regardless of financial dependency, residency with you, marital status, or student status; or
- your unmarried child of any age who is principally supported by you and who is not capable of self-support due to a physical or mental disability that began while the child was covered by the Plan.
- your unmarried child of any age who is not capable of self-support due to a physical or mental disability that occurred before age 26, whose disability is continuous, and who is principally supported by you

"Principally supported by you" means that the child is dependent on you for more than one-half of his or her support, as defined by Code Section 152 of the Internal Revenue Code.

For purposes of the Plan, your child includes:

- your biological child;
- your legally adopted child (including any child lawfully placed for adoption with you);
- your stepchild;
- a foster child who has been placed with you by an authorized placement agency or by judgment decree or other court order;
- a child for whom you are the court-appointed legal guardian;
- an eligible child for whom you are required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN).

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the Company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children.

It is your responsibility to notify the Company if your dependent becomes ineligible for coverage.

### Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated time period. If you fail to do so, coverage for your dependent may be canceled.

## When Coverage Begins

### Monthly Measurement Method for Determining Full-time Employee Status

The Company uses a monthly measurement method to determine who is a full-time employee for purposes of the Plan's health care benefits. The monthly measurement method is based on Internal Revenue Service (IRS) final regulations. The monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. In general, an employee will be treated as full-time for any month in which he or she averages at least 30 hours of service per week (or 130 hours of service in a calendar month). An employee will generally be ineligible for the Plan's health care benefits for any month in which he or she averages less than 30 hours of service per week (or 130 hours per calendar month).

The Company intends to follow applicable IRS guidance when administering the monthly measurement method. If you have any questions about this measurement method and how it applies to you, please contact the Plan Administrator.

#### For You

Your health care coverage begins on the first day of the month following your date of hire and after you meet all eligibility requirements.

If you terminate employment and are subsequently rehired, you will be treated as a new employee and will need to satisfy all eligibility requirements in order to be covered under the Plan.

#### For Your Dependents

Coverage for your eligible dependents begins on the same day as your initial eligibility provided you timely enroll your dependents in coverage.

If you acquire a new dependent through marriage, birth, adoption or placement for adoption, you can add your new dependent to your coverage as long as you enroll the dependent within 31 days of the date on which they became eligible. If you wait longer than 31 days, you may be required to wait until the Plan's next open enrollment period to enroll your new dependent for coverage.

A newborn child will be automatically covered by the Plan while the birth mother is hospital-confined. Coverage will continue only if you enroll him or her on your coverage within 31 days of birth. If you wait longer than 31 days after the date of birth, you may not be able to enroll your newborn child until the next annual open enrollment period.

Charges for nursery or physician care will be initially applied toward the plan of the covered parent. If the newborn child is not enrolled in the Plan on a timely basis, the covered parent will be responsible for all costs.

## Your Cost for Coverage

Both the Company and you share in the cost of your health care benefits. Each year, the Company will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. Your enrollment materials will show the coverage categories available to you.

You pay your portion of this cost through pre-tax payroll deductions taken from your pay each pay period. Your actual cost is determined by the coverage you select and the number of dependents you cover. You must elect coverage for yourself in order to cover your eligible dependents.

## Enrolling for Coverage

### New Hire Enrollment

As a newly eligible employee, you will receive enrollment information when you first become eligible for benefits. To enroll in medical and/or prescription drug coverage, you will need to make your coverage elections by the deadline shown in your enrollment materials. When you enroll in the Plan, you authorize the Company to deduct any required premiums from your pay.

The elections you make will remain in effect until the next December 31, unless you have a qualifying change in status. After your initial enrollment, you will enroll during the designated annual open enrollment period. If you do not enroll for coverage when initially eligible, you will only be eligible for the default coverages designated by the Plan Administrator, as shown in your enrollment materials.

## Annual Open Enrollment

Each year during a designated open enrollment period, you will be given an opportunity to make your elections for the upcoming year. Your open enrollment materials will provide the options available to you and your share of the premium cost, as well as any default coverage you will be deemed to have elected if you do not make an election by the specified deadline.

The elections you make will take effect on the following January 1 and stay in effect through December 31, unless you have a qualifying change in status.

## Effect of Section 125 Tax Regulations on this Plan

It is intended that this Plan meets the requirements of the Internal Revenue Code Section 125 and the regulations thereunder and that the qualified benefits which you may elect are eligible for exclusion from income. The Plan is designed and administered in accordance with those regulations. This enables you to pay your share of the cost for coverage on a pre-tax basis. Neither the Company nor any fiduciary under the Plan will in any way be liable for any taxes or other liability incurred by you by virtue of your participation in the Plan.

Because of this favorable tax-treatment, there are certain restrictions on when you can make changes to your elections. Generally, your elections stay in effect for the Plan Year and you can make changes only during each annual open enrollment. However, at any time throughout the year, you can make changes to your coverage within 31 days following:

- The date you have a qualifying change in status as described below;
- The date you meet the Special Enrollment Rights criteria described below.

## Qualifying Change in Status

If you experience a change in certain family or employment circumstances that results in you or a covered dependent gaining or losing eligibility under a health plan, you can change your coverage to fit your new situation without waiting for the next annual open enrollment period.

As defined by the Internal Revenue Service (IRS), status changes applicable to health care coverage include:

- your marriage;
- the birth, adoption, or placement for adoption of a child;
- your death or the death of your spouse or other eligible dependent;
- your divorce, annulment, or legal separation;
- a change in a dependent child's eligibility due to age or eligibility for other coverage;
- a reduction or loss of your or a dependent's coverage under this or another plan;
- a court order, such as a QMCSO or NMSN, that mandates coverage for an eligible dependent child;

If you experience a change in certain family or employment circumstances, you can change your coverage. Changes must be consistent with status changes as described above. For example, if you get married, you may change your coverage level from you only to you and your spouse. If you move, and your current coverage is no longer available in the new area, you may change your coverage option.

You should report a status change as soon as possible, but no later than 31 days, after the event occurs.

Keep in mind that certain mid-year election change events do not apply to health Flexible Spending Accounts (FSAs), such as cost or coverage changes. Contact the Plan Administrator if you have questions about when you can change your elections.

## Special Enrollment Rights

If you decline enrollment for yourself or your dependents (including your spouse) because you have other health coverage, you may be able to enroll yourself and your dependents in this Plan, if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

You or an affected eligible dependent may also enroll in coverage if eligibility for coverage is lost under Medicaid or the Children's Health Insurance Program (CHIP), or if you become eligible for premium assistance under Medicaid or CHIP. You must enroll under this Plan within 60 days of the date you lose coverage or become eligible for premium assistance.

This "special enrollment right" exists even if you previously declined coverage under the Plan. You will need to provide documentation of the change. Contact the Plan Administrator to determine what information you will need to provide.

## When Coverage Ends

Your coverage under this Plan ends on the last day of the month in which your employment terminates or you cease to be an eligible employee unless benefits are extended as described below.

Coverage for your covered dependents ends when your coverage ends or, if earlier, on the last day of the month in which your dependent is no longer eligible for coverage under the Plan.

Coverage will also end for you and your covered dependents as of the date the Company terminates this Plan or, if earlier, the effective date you request termination of coverage for you and your covered dependents.

If your coverage under the Plan ends for reasons other than the Company's termination of all coverage under the Plan, you and/or your eligible dependents may be eligible to elect to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) as described below.

## Cancellation of Coverage

If you fail to pay any required premium for coverage under the Plan, coverage for you and your covered dependents will be canceled and no claims incurred after the effective date of cancellation will be paid.

## Rescission of Coverage

Coverage under the Plan may be rescinded (canceled retroactively) if you or a covered dependent performs an act, practice or omission that constitutes fraud, or you make an intentional misrepresentation of material fact as prohibited by the terms of the Plan. A rescission of coverage is an adverse benefit determination that you may dispute under the

Plan's claims and appeals procedures. If your coverage is being rescinded due to fraud or intentional misrepresentation of material fact, you will receive at least 30 days' advance written notice of the rescission. This notice will outline your appeal rights under the Plan. Benefits under the Plan that qualify as "excepted benefits" under HIPAA are not subject to these restrictions on when coverage may be rescinded. Some types of retroactive terminations of coverage are permissible even when fraud or intentional misrepresentation are not involved. Coverage may be retroactively terminated for failure to timely pay required premiums or contributions as required by the Plan.

Also, coverage may be retroactively terminated to the date of your divorce if you fail to notify the Plan of your divorce and you continue to cover your ex-spouse under the Plan. Coverage will be canceled prospectively for errors in coverage or if no fraud or intentional misrepresentation was made by you or your covered dependent.

The Plan reserves the right to recover from you and/or your covered dependents any benefits paid as a result of the wrongful activity that is in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on your behalf, continuation coverage under COBRA may be denied to you and your covered dependents.

### Coverage While Not at Work

In certain situations, health care coverage may continue for you and your dependents when you are not at work, so long as you continue to pay your share of the cost. If you are not receiving your pay during an absence, you will need to make arrangements for payment of any required premiums. You should discuss with your supervisor what options are available for paying your share of costs while you are absent from work.

### If You are Totally Disabled

If you become totally disabled, your health care coverage may continue for up to 12 months, concurrent with any leave that is designated as FMLA, as long as you continue to pay your share of the cost.

### If You are Temporarily Laid Off

If you are laid off for a temporary period of time, your health care coverage will continue for up to 3 months from the date of layoff, as long as you continue to pay your share of the cost.

### If You Take a Leave of Absence – FMLA

If you take an approved FMLA leave, your coverage will continue for the duration of your FMLA leave, as long as you continue to pay your share of the cost as required under the Company's FMLA Policy.

### If You Take a Leave of Absence – Non-FMLA

If you take an approved leave of absence (paid or unpaid), your coverage will continue.

### If You Take a Military Leave of Absence

If you are absent from work due to an approved military leave, health care coverage may continue for up to 24 months under both the Uniformed Services Employment and

Reemployment Rights Act of 1994 (USERRA) and COBRA, which run concurrently, starting on the date your military service begins.

# Your Medical Benefits

Your medical benefits are delivered through a network of participating doctors, hospitals, laboratories, home health care agencies, and other health care providers, who have agreed to provide services at a discounted cost.

You do not need prior authorization from the Plan or claims administrator, or from any other person (including your PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

A network of providers gives you the flexibility to choose providers inside or outside the network each time you need care. In most cases, the Plan covers the same medical services whether you receive care in- or out-of-network. Refer to the benefit summary booklet issued by your Claims Administrator, Independent Health, for a more detailed summary of your health care benefits and how benefit are paid in- and out-of-network. The benefit summary booklet is incorporated by reference as part of this SPD.

To select a PCP, or to obtain a listing of current providers (at no cost to you) or confirm whether a provider participates in the network, contact the Claims Administrator.

**If you use in-network providers,** the Plan pays a higher percentage of covered expenses (after you meet any applicable deductible). Generally, you will not be required to file a claim form when you receive in-network benefits but in some cases, the provider or claims administrator may require you to do so.

If you receive professional services for anesthesiology, radiology, emergency room physician services, or pathology which are provided by an out-of-network provider but rendered at in-network facility, those services will be paid at the in-network level of benefits.

**If you use out-of-network providers,** the Plan pays a lower percentage of covered expenses (after you meet any applicable deductible), up to the reasonable and customary limit or maximum plan allowance (see explanation below). You are responsible for charges in excess of this limit and this excess amount may not apply to your deductible or any out-of-pocket maximum. You may also pay a higher deductible and out-of-pocket maximum (if applicable) out-of-network, and you may be required to file claim forms. Refer to your benefit summary booklet for additional information.

**If you live in an area where no in-network provider is available within 100 miles of your residence,** the Plan will apply and pay services at the in-network level of benefits.

## Your Deductible

A deductible is money you must pay for certain covered expenses before the Plan pays benefits. It is calculated on a calendar year basis.

## Your Co-payment

Some services may require a co-payment – a fixed dollar amount you must pay before the Plan pays for that service. Copayments may apply regardless of whether the deductible has been satisfied. Please refer to the Summary of Medical Benefits chart for any required copayments and if the deductible may need satisfied before copayments are applied.

## Your Coinsurance

Once you meet your deductible, the Plan pays a portion, or percentage, of certain covered medical expenses, and you are responsible to pay a portion. The percentage you must pay is called your coinsurance. For most services, the Plan will pay a higher percentage of the cost when you receive care in-network, which means your percentage will be lower.

The amount or percentage you pay depends on the type of provider you see, where you receive services, and how you are billed for these services. Your benefit summary booklet provided by the Claims Administrator will show the co-payment and coinsurance amounts for common medical services both in-network and out-of-network.

## Out-of-Pocket Maximum

The out-of-pocket maximum limits the total portion of costs you must pay in annual medical deductibles, coinsurance and copayments. It is calculated on a calendar year basis. When your share of eligible out-of-pocket medical expenses reaches the out-of-pocket maximum, your coinsurance percentage and copayments become zero for the rest of the year – and the Plan pays 100% of covered expenses. Your benefit summary booklet will show any applicable out-of-pocket maximum amounts.

## Maximum Allowed Amount (Reasonable/Usual and Customary Limits)

If you use out-of-network providers, covered medical expenses are subject to certain limits under the Plan, and you are responsible for paying any charges above this limit. The maximum benefit payable is based on the amount determined by the Plan to be the prevailing charge for a covered service or supply. Determination of the prevailing charge is based on the:

- complexity of the service and level of specialty of the provider;
- range of services provided; and
- the geographic area where the provider is located and other geographic areas with similar medical cost experience.

## Eligible Expenses

Eligible expenses are for services and supplies that are approved by a physician or other approved provider and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy or other covered health care condition. Services received from an out-of-network provider are subject to the Reasonable and Customary limit (see above). Refer to your benefit summary booklet for additional information.

## For More Information

If you have a question about a covered service, or for more information about a specific procedure or service described above, contact the Claims Administrator.

## Expenses Not Covered

Ineligible expenses and expenses not covered by the plan are shown in the benefit summary booklet provided by your Claims Administrator.

## Precertification

You and your covered dependents are required to obtain precertification for inpatient hospitalization (and certain other treatments) as shown in your benefit summary booklet. In some cases, the in-network provider may obtain the precertification for you; however, to ensure that you receive the maximum benefit, you should verify that the request was submitted to the Plan.

To receive the maximum benefit and avoid any penalty for failure to pre-certify, you must call the number listed on the back of your ID card to pre-certify an admission or treatment:

- at least 2 weeks prior to any scheduled or non-emergency hospital admission or treatment;
- within 48 hours of an emergency or unscheduled admission. Your case will be reviewed by the Plan to determine how many days of treatment are medically necessary.

## Precertification - Pregnancy and Childbirth

Precertification will not be required for an inpatient admission for pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery.

## Penalty for Noncompliance with Precertification

If precertification requirements are not met, any covered expenses incurred will be reduced by 50%. In addition, if it is determined subsequently that all or part of the hospital stay was not medically necessary, all or part of the hospital confinement expenses will be denied and benefits will not be paid beyond the number of days considered medically necessary.

The precertification coordinator will work with your physician to determine the appropriate length of stay for your condition. If an extension is required for your hospital confinement, you (or a family member or your attending physician) must obtain approval for the extension before the original approved stay expires. If an extension is approved, you, your attending physician, and the hospital will receive written notification of the approval. If the criteria for an extended stay are not met, your stay will be denied and you may file an appeal of the denial through the Plan's appeal process.

## Case Management

Through the case management program, you receive appropriate health care services for serious or catastrophic medical conditions. The Plan Administrator may arrange for review and/or case management from a professional who is qualified to perform such services. The Plan Administrator has the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost-effective result without sacrificing the quality of patient care. The case management program may provide benefits or alternative care not otherwise routinely available through the Plan under special circumstances.

While many diagnoses may require special attention, the Plan may use case management for conditions such as, but not limited to:

- Acquired Immune Deficiency Syndrome (AIDS);
- burns;

- coma;
- inpatient confinement expected to exceed 14 days;
- multiple sclerosis/Amyotrophic Lateral Sclerosis (Lou Gehrig's disease);
- neonatal birth;
- organ transplant;
- progressive neurological debilitative disease;
- certain psychiatric conditions;
- quadriplegic/paraplegic conditions;
- stroke; and
- multiple traumas from a vehicular accident.

Benefits provided under the program are subject to all other Plan provisions. Alternative treatments will be determined on the merits of each individual case and will not be considered as setting any precedent or creating any future liability with respect to any participant. Case management will be involved for in-network and out-of-network services that meet the established criteria.

## MEDICAL PLAN COVERED SERVICES

Covered Services fees are determined either by the rates agreed upon with a Participating Provider or the Usual, Customary and Reasonable Charges with respect to covered services rendered by a Non-Participating Provider that are incurred for the following items of service and supply. **These Covered Services are subject to the limitations (as set forth in the Schedule of Benefits), Exclusions and other provisions of this SPD.** A charge is incurred on the date that the service or supply is performed or furnished. In addition to the provisions set forth below, the Plan utilizes certain Independent Health policies and procedures with respect to Covered Services under the Plan.

- **Alcohol and Substance Abuse.**
- **Allergy** (testing, injections, and serum).
- **Ambulance.** Use of Ambulance services (land or air) may be reviewed retrospectively for Medical Necessity.
- **Anesthesia.**
- **Assistant Surgeon.**
- **Autologous Blood.**
- **Blood and Plasma.**
- **Cardiac Rehabilitation.**
- **Chemotherapy and Radiation.** The materials and services of technicians are included.
- **Chiropractic Care.**
- **Clinical Trials.** The Plan will cover "Routine Patient Costs" for a "Qualified Individual" participating in an "Approved Clinical Trial." For purposes of this coverage, the following definitions apply:
    a) **Routine Patient Costs** means all items and services consistent with Plan coverage that is typically covered for a Participant who is not enrolled in a Clinical Trial.

    b) **Qualified Individual** means a Participant who is eligible to participate in an Approved Clinical Trial according to trial protocol with respect to treatment of cancer or other Life-Threatening Condition and either the (i) Participant's Physician has concluded that participation is appropriate, or (ii) Participant provides medical and scientific information establishing that their participation is appropriate.

    c) **Approved Clinical Trial** means a Phase I, II, III or IV Clinical Trial for the prevention, detection or treatment of cancer or other Life-Threatening Condition or disease (or other condition described in the Affordable Care Act) such as federally funded trials (identified in the Affordable Care Act), trials conducted under an Investigational new drug application reviewed by the FDA or drug trials exempt from having an investigational new drug application.

    **d) Life-Threatening Condition** means any disease from which the likelihood of death is probable unless the course of the disease is interrupted.
- **Contraceptives.**
- **Dental.** Medically Necessary Dental care and treatment due to accidental Injury to sound natural teeth occurring within 12 months from the date of the accidental Injury, and Dental care and treatment Medically Necessary due to congenital disease or anomaly.
- **Diabetic Equipment and Supplies.**
- **Diabetic Teaching.** (covered under Preventive Services).
- **Diagnostic Testing.**
- **Dialysis.**
- **Durable Medical Equipment.** Rental of Durable Medical Equipment or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Claims Administrator.
- **Electroconvulsive Therapy.**
- **Emergency Care** (facility and Physician/Provider).
- **Experimental and/or Investigational.** Experimental and/or Investigational treatments, procedures, drugs and devices are generally not a Covered Service. See Plan Exclusion for exceptions.
- **Family Counseling.**
- **Hearing.** Medically Necessary hearing tests ordered by a Physician/Provider.
- **Hearing Aids.** Only Cochlear Implant and Bone Anchored Hearing Aid (BAHA) are covered. Must be FDA approved.
- **Home Health Care.** When ordered by a Physician/Provider in accordance with a treatment plan approved in writing by the Medical Director as an alternative to (or to prevent) hospitalization or treatment in a Skilled Nursing Facility. Services eligible for coverage include: a) part-time or intermittent home nursing care by or under the supervision of a registered professional nurse; b) part-time or intermittent home health aide which consists primarily of caring for the Plan Participant; c) physical, Medical Supplies or Speech Therapy which consists primarily of caring for the Plan Participant; d) Medical Supplies that are rendered in the home; e) drugs and medications, including Home Infusion

Therapy prescribed by a Physician/Provider; and f) Laboratory Services by or on behalf of the Home Health Agency, to the extent such items would have been covered or provided if the Plan Participant were hospitalized or confined in a Skilled Nursing Facility.

- **Home Infusion Therapy.**
- **Home Visits.**
- **Hospice.** Coverage for Advanced Care Planning, inpatient care, outpatient care, home care, and bereavement counseling.
- **Hospital** (facility and Physician/Provider).
- **Immunizations.**
- **Infertility.** Evaluation, testing and diagnostic services as set forth below (see Plan Exclusions for specific services not covered). The Infertility benefit does not cover treatment for the partner, if the partner is not a Plan Participant under the Plan.
- **Injections.**
- **Laboratory and Pathology.**
- **Mammograms.**
- **Mastectomy.** This Plan covers: a) all stages of reconstruction of the breast on which the Mastectomy was performed; Surgery and reconstruction of the other breast to produce a symmetrical appearance; b) Prostheses; and c) treatment for physical complications at all stages of Mastectomy, including lymphedemas, in the manner determined in consultation with the attending Physician/Provider and the Plan Participant.
- **Maternity Care.** Obstetrical services. A Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician/Provider and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

  Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Physician/Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a Physician/Provider obtain authorization from the plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

  Home births are a Covered Service under the Plan when performed by a Physician/Provider who meets credentialing standards established by Nova Healthcare.
- **Medical Services and Supplies.**
- **Mental Health.**
- **MRI / MRA / CAT / Nuclear.**
- **Nutritional Counseling** (covered under Preventive Services).
- **Occupational Therapy.**
- **Office Visits.**
- **Orthotics.** See Plan Exclusions for specific services not covered
- **Ostomy Supplies.** See Prosthetics and Appliances.
- **Outpatient Surgical Procedures.**
- **Pap Smear.**
- **Physical Therapy.**
- **Physician/Provider Visit.** Coverage is available for Physician/Provider's services when a Plan Participant is in the Hospital, Skilled Nursing Facility, outpatient facility, in Physician's office or Participant's home.
- **Podiatry.** See Plan Exclusions for specific services not covered.
- **Preadmission Testing.**
- **Preventive Services.** The services will include all services designated as Preventive by the United States Preventive Services Task Force and their corresponding limitations.
- **Prostate Screening.**
- **Prosthetics and Appliances (P&A).** Includes: a) the purchase, fitting and repair of fitted Prosthetic devices and Medical appliances which replace body parts, including Ostomy supplies; and b) replacement, repair and maintenance are covered when functionally necessary if it is not covered under manufacturer's warranty or purchase agreement and not the result of misuse. Medically Necessary orthopedic devices dispensed at a Physician/Provider's office will be covered under the Physician Visit benefit
- **Pulmonary Rehabilitation.**
- **Radiation Therapy.**
- **Radiology** (X-Rays).
- **Routine Physicals.**

- **Second Surgical Opinions.**
- **Skilled Nursing Facility.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when: a) the Plan Participant is confined as a bed patient in a facility; b) the attending Physician/Provider certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and c) the attending Physician/Provider completes a treatment plan which includes a Diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.
- **Sleep Studies.** Medically Necessary for the Diagnosis and treatment of sleep disorders.
- **Speech Therapy**. Therapy must be ordered by a Physician/Provider and follow either: a) Surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; b) an Illness or Injury; or c) an Illness that is other than a learning or Mental Health Condition.
- **Sterilization.**
- **Temporomandibular Joint (TMJ) Treatment.** Will only be covered if the TMJ is the direct cause of another medical condition.
- **Termination of Pregnancy.** Only covered when the women's life would be in danger if the fetus was carried to term or when the pregnancy is the result of rape or incest.
- **Tobacco Cessation.** Charges incurred for tobacco cessation classes and products are covered as described in the Schedule of Benefits.
- **Transplants.** Benefits for service rendered in a Center of Excellence will be based on the service rendered (Example: surgeon's charges under the physician benefit). Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:
    a) Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.
    b) No transportation, companion food or lodging charges will be considered.
    c) Claims need to be submitted to the donor's insurance carrier. An EOB from the other insurance carrier then needs to be submitted to Nova Healthcare. Nova Healthcare will reimburse for the donation charges under the recipient's ID number if the other insurance carrier denies the claim or if there is a balance remaining once the other carrier has paid. Nova Healthcare will coordinate benefits.
    d) The Plan will always pay secondary to any other coverage. Donor coverage for transplants provided only if not covered under donor's plan. Donor charges in those cases will be coordinated with any primary plan and covered under the recipient's identification number.
    e) Organ recipients must be a Covered Person under the Plan.
    f) Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for: evaluating the organ or tissue; removing the organ or tissue from the donor; and transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
- **Urgent Care.**
- **Vasectomy.**
- **Vision.** Medically Necessary eye examinations for the treatment of Illness or Injury.
- **Well Child Care.**
- **Women's Wellness.**

# Medical Plan
# Schedule of Benefits

This SPD discusses the Medical Plan benefit options under the Plan.

All benefits described in the Schedule are subject to the Exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's and/or Claims Administrator's determination that: 1) care and treatment is Medically Necessary; 2) charges are Usual, Customary and Reasonable; and 3) services, supplies and care are not Experimental and/or Investigational.

A Plan Participant should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

# SCHEDULE OF BENEFITS

| ENCOMPASS B<br>(10/20/35, 7/15/30,7/25/40,7/20/40) | | |
|---|---|---|
| **Benefit Description** | **In-Network** | **Out-of-Network** |
| Deductible | Not Applicable | $250 per Individual<br>$500 per Family<br><br>On an Individual policy, the individual deductible must be met before IH provides reimbursement for covered services.<br><br>On a Family policy, once a family member meets the individual deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family deductible before IH provides reimbursement for covered services. |
| Out-of-Pocket Maximum | $2,000 per Individual<br>$4,000 per Family<br><br>Pharmacy OOP max single $4,600/Family $9,200 not shared with medical.<br><br>The in-network copayments and coinsurance apply to the in-network out-of-pocket max.<br><br>On an Individual policy, the individual in-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network services.<br><br>On a Family policy, once a family member meets the individual in-network out-of-pocket max IH will provide 100% reimbursement of the allowed amount for covered in-network services.<br><br>However, additional family members must satisfy the family in-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered in-network services.<br><br>Note: Once the in-network out-of-pocket max is met, the member will not be responsible for any in-network deductible, copayments or coinsurance.<br><br>Maximums DO NOT cross apply. In network does not apply towards out of network and out of network does not apply towards in network. | $2,000 per Individual<br>$4,000 per Family<br><br>The out-of-network deductible, copayments and coinsurance apply to the out-of-network out-of-pocket max.<br><br>On an Individual policy, the individual out-of-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered out-of-network services.<br><br>On a Family policy, once a family member meets the individual out-of-network out-of-pocket max, the out-of-pocket max is satisfied for that member. However, additional family members must satisfy the family out-of-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered out-of-network services.<br><br>Note: Once the out-of-network out-of-pocket max is met, the member will not be responsible for any out-of-network deductible, copayments or coinsurance.<br><br>Maximums DO NOT cross apply. In network does not apply towards out of network and out of network does not apply towards in network. |
| Coinsurance | See specific benefit | 20% unless otherwise noted |
| Usual, Customary and Reasonable Rate | Not applicable | 90th Percentile.<br>Covered Person may be balanced billed for the difference between UCR and billed charges. If UCR rate is not available and IH cannot negotiate a rate, billed charges apply |
| Pre-Certification | **Call Independent Health's Utilization Management Department at (716) 631-2661 or (800) 257-2753.** | |
| Penalty for Failure to Pre-Certify | N/A | 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. |
| Coordination Of Benefits Procedures | Refer to the Coordination of Benefits Section in the SPD for details. | |
| PCP Required? | PCP is required | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **ACUPUNCTURE – NOT COVERED** | | | | |
| **ALCOHOL/SUBSTANCE ABUSE (ACUTE CONDITIONS ONLY)** | | | | |
| *Inpatient Facility Detox Only* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| *Inpatient Rehabilitation Facility* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| *Inpatient Rehabilitation Physician* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Outpatient* | Plan pays 100% After $10 Copay. | N | Plan pays 80% After Deductible. | N |
| *Family Therapy* | Plan pays 100% After $10 Copay. | N | Plan pays 80% After Deductible. | N |
| *Residential Treatment* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| **ALLERGY TESTING & TREATMENT** | | | | |
| *Allergy Testing & Treatment* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| *Allergy Serum* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Rast Testing* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **AMBULANCE** | | | | |
| *Ambulance* | Plan pays 100% After $50 copay. | N | Covered as In-Network Benefit | N |
| **ANESTHESIA** | | | | |
| *Inpatient* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Outpatient* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Pain Management* | See Outpatient Surgical Procedures | | | |
| **ARTIFICIAL INSEMINATION** | | | | |
| *Artificial Insemination* | Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate.<br><br>Applicable member liability based on services rendered. | N | Coverage is pursuant to the eligibility requirements and conditions outlined by the NYS Infertility mandate.<br><br>Plan pays 80% After Deductible. | Y |
| **ASSISTANT SURGEON** | | | | |
| *Inpatient* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Outpatient* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **AUTISM** | | | | |
| *Assessment for Autism* | Not covered. | N | Plan pays 80% After Deductible. | N |
| *Applied Behavioral Analysis (ABA)* | Not Covered. | N | Not Covered. | N |
| *ABA Treatment* | Not Covered. | N | Not Covered. | N |
| *Assistant Communication Devices (ACD)* | Not Covered. | N | Not Covered. | N |
| **AUTOLOGOUS BLOOD** | | | | |
| *Autologous Blood* | Plan pays 80%. | N | Plan pays 80% After Deductible. | N |
| **CARDIAC REHABILITATION (LIMIT 36 VISITS PER EVENT. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |
| *Cardiac Rehabilitation* | Plan pays 100% After $10 copay.<br><br>Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction. | N | Plan pays 80% After Deductible.<br><br>Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction. | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **CHEMOTHERAPY TREATMENT (CANCER)** | | | | |
| *Chemotherapy Treatment (Cancer)* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| **CHIROPRACTIC CARE** | | | | |
| *Chiropractic Care* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| **CONTRACEPTIVES** | | | | |
| *Contraceptives administered in the provider's office* | Devices dispensed in the office covered in full as a Medical benefit.<br><br>For insertion, removal or fitting of device, Plan pays 100% after:<br><br>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<br><br>Prior to 07/01/2014: Mirena - must be obtained through a Specialty Pharmacy, covered in full.<br><br>Prior to 07/01/2014 Implanon – must be obtained through a Specialty Pharmacy, covered in full. The specialty pharmacy dispensing program for these devices is no longer mandatory. | N | Devices/injections dispensed in the office covered as a Medical benefit. Plan pays 80% Coinsurance after Deductible.<br><br>For insertion, removal or fitting of device, Plan pays 80% Coinsurance after Deductible. | N |
| *Contraceptive Injectable* | Injections administered in the office: Plan pays 100%<br><br>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 | Plan pays 80% After Deductible. | N |
| *Contraceptives self-administered/used by the member* | See Pharmacy Benefit | N | See Pharmacy Benefit | N |
| **COSMETIC SURGERY** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Cosmetic Surgery* | Not covered unless for reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved body part.<br><br>Member liability based on services rendered when deemed medically necessary. | Y | Not covered unless for reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved body part.<br><br>Member liability based on services rendered when deemed medically necessary. | Y<br><br>Failure to pre-certify will result in denial to the Covered Person |
| **DENTAL** | | | | |
| *Preventive and Routine* | Not Covered | N | Not Covered | N |
| *Accidental Dental* | Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within twelve months of the accident.<br><br>Member liability based on services rendered when deemed medically necessary. | N | Covered as In-Network Benefit | N |
| *Congenital Disease and Anomaly* | Member liability based on services rendered when deemed medically necessary. | N | Member liability based on services rendered when deemed medically necessary. | Y |
| **DIABETIC** | | | | |
| *Insulin, Oral Agent (30 Day Supply)* | Plan pays 100% After $10 copay. | N | See Pharmacy Benefit | N |
| *Diabetic Supplies (30 Day Supply)* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Diabetic Equipment (e.g. Blood Glucose Monitor)* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Diabetic Equipment Insulin Pump* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Diabetic Teaching* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Diabetic Shoes and Inserts* | Not Covered | N | Not Covered | N |
| **DIAGNOSTIC TESTING** | | | | |
| *Diagnostic Testing (e.g. EKG, Stress Tests, not Lab or X-rays)* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **DIALYSIS** | | | | |
| *Outpatient Facility* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| *Outpatient Physician* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | N |
| **DURABLE MEDICAL EQUIPMENT (DME)** | | | | |
| *Durable Medical Equipment (DME)* | Plan pays 80% | N | Plan pays 50%<br>After Deductible.<br><br>Up to an annual maximum of $1,000 per covered person per calendar year. | Y |
| **ELECTROCONVULSIVE THERAPY (ECT) - SEE MENTAL HEALTH** | | | | |
| **EMERGENCY CARE** | | | | |
| *Emergency Room Facility - also see Urgent Care* | Plan pays 100%<br>After $50 copay.<br><br>Copayment waived if admitted | N | Covered as In-Network Benefit | N |
| *ER Physician/Provider* | Plan pays 100%. | N | Covered as In-Network Benefit | N |
| *ER Follow up Visit* | Office visit or Emergency room copayment may apply. | N | Covered as In-Network Benefit | N |
| *Observation Beds – Facility* | Plan pays 100%<br>After $50 copay.<br><br>Copayment waived if admitted | N | Covered as In-Network Benefit | N |
| *Observation Beds – Physician* | Plan pays 100%. | N | Covered as In-Network Benefit | N |
| **HEARING** | | | | |
| *Hearing Tests* | Plan pays 100%<br>After Office Visit copay. | N | Plan pays 80%<br>After Deductible. | N |
| *Evaluation and Fitting for Hearing Aids* | Not Covered | N | Not Covered | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Hearing Aids* | Not Covered<br><br>Exception: Cochlear Implant and Bone Anchored Hearing Aid BAHA. Only FDA approved devices are covered. | N | Not Covered<br><br>Exception: Cochlear Implant and Bone Anchored Hearing Aid BAHA. Only FDA approved devices are covered. | N |
| **HOME HEALTH CARE/ AIDE (LIMIT 40 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |
| *Home Health Care/ Aide*<br>*1 Home Health Aide visit = up to 4 continuous hours* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | Y |
| *Private Duty Nursing* | Not Covered | N | Not Covered | N |
| **HOME INFUSION THERAPY (FOR ENTERNAL AND PARENTERAL SEE NUTRITIONAL SUPPLIES)** | | | | |
| *Nursing Services/Visits* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | Y |
| *Medication* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | Y |
| *Other Services (e.g. supplies and per diem items)* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | Y |
| **HOME VISITS** | | | | |
| *Home Visits (other than Home Health Care or Home Infusion Therapy)* | Plan pays 100%<br>After Office Visit copay. | N | Plan pays 80%<br>After Deductible. | N |
| **HOSPICE (INCLUDES BEREAVEMENT COUNSELING)** | | | | |
| *Advance Care Planning*<br>*(this benefit includes the Caring Hearts Perinatal Program)* | Plan pays 100%.<br><br>Limit 6 visits<br>Per Calendar Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N | Plan pays 80%<br>After Deductible.<br><br>Limit 6 visits<br>Per Calendar Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N |
| *Inpatient* | Plan pays 100% | N | Plan pays 80%<br>After Deductible. | N |
| *Outpatient (Home)* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **HOSPITAL** | | | | |
| *Hospital – Inpatient Facility* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| *Hospital - Inpatient Medical Rehab Facility* | Plan pays 100%<br><br>Limit 45 days Per Plan Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N | Plan pays 80% After Deductible.<br><br>Limit 45 days Per Plan Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | Y |
| **IMMUNIZATIONS (IF DONE IN CONJUNCTION WITH AN OFFICE VISIT THEN OFFICE VISIT COPAY MAY APPLY)** | | | | |
| *Adult Immunizations (19 years and over)* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Flu & Pneumonia Immunizations (19 years and over)* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Hepatitis B Immunizations (19 years and over)* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Travel Immunizations (19 years and over)* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Well Child Immunizations (0-18 years)*<br><br>*ACIP = Advisory Committee for Immunization Practices* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| **INFERTILITY** | | | | |
| *Infertility* | Coverage is pursuant to the eligibility requirements and conditions outlined by the Summary Plan Description.<br><br>Member liability based on services rendered. | N | Coverage is pursuant to the eligibility requirements and conditions outlined by the Summary Plan Description.<br><br>Plan pays 80% After Deductible. | Y |
| **INJECTIONS** | | | | |
| *Injections – Office-Based (not self-administered)* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| **LABORATORY & PATHOLOGY** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Laboratory & Pathology* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **MAMMOGRAMS** | | | | |
| *Professional Services* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Technical Services* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **MASTECTOMY/POST-MASTECTOMY** | | | | |
| *Breast Prosthesis* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Post Mastectomy Supplies (Bras)* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Reconstructive Surgery* | See Hospital and Outpatient Surgical Benefit. | N | See Hospital and Outpatient Surgical Benefit. | N |
| **MATERNITY CARE** | | | | |
| *Breast Feeding/ Lactation Support* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Prenatal & Postnatal Visits*<br><br>*Note: If a visit is unrelated to Pregnancy, Covered Person liability may apply based on services rendered.* | Plan pays 100% After initial Diagnosis | N | Plan pays 80% After Deductible. | N |
| *Sonogram(s)* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Facility – Delivery* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| *Facility – Physician* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Newborn – Facility* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Newborn – Physician* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Home Visit (Resulting from early discharge)* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Home Birth (Per Independent Health guidelines)* | Plan pays 100%. | N | Plan pays 80% After Deductible. | Y |
| **MEDICAL SUPPLIES** | | | | |
| *Medical Supplies* | Plan pays 100%. | N | Plan pays 80% After Deductible. | Y |
| **MEDICAL EXPENDABLE SUPPLIES** | | | | |
| *Medical Expendable Supplies* | Plan pays 100%.<br><br>When in conjunction with authorized skilled nursing services in the home | N | Plan pays 80% After Deductible.<br><br>When in conjunction with authorized skilled nursing services in the home | Y |
| **MENTAL HEALTH** | | | | |
| *Electroconvulsive Therapy (ECT) (e.g. Shock Therapy) Facility Outpatient Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Electroconvulsive Therapy(ECT) (e.g. Shock Therapy) Physician/Provider Outpatient Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Mental Health Inpatient Facility* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| *Mental Health Inpatient Physician/Provider* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Mental Health Outpatient* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Mental Health Partial Hospitalization*<br><br>*Care that is provided in lieu of inpatient mental health hospitalization at an approved facility* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | Y |
| *Pharmacological (chemotherapy) Management*<br><br>*A brief interaction between a psychiatrist and a member for the primary purpose of reviewing medications and issuing a prescription with minimal psychotherapy* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Residential Treatment*<br><br>*Intensive Residential Rehabilitation Services are Residential Services requiring 24/7 treatment in a structured* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *environment.*<br><br>*Note: Community Residential Services and Supportive Living Services are NOT covered.* | | | | |
| **MRI & MRA – SEE RADIOLOGY SERVICES (ADVANCED)** | | | | |
| **NUTRITIONAL COUNSELING** | | | | |
| *Nutritional Counseling* | Plan pays 100% | N | Plan pays 80%<br>After Deductible. | N |
| **NUTRITIONAL SUPPLIES** | | | | |
| *Enteral & Parenteral Pumps* | See DME Benefit | N | See DME Benefit | N |
| *Parenteral Nutritional Supplies*<br><br><u>Parenteral Nutrition</u><br>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. | Plan pays 100%.<br><br>If provided in conjunction with Home Infusion Visit. | N | Plan pays 80%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | Y |
| *Enteral Formula & Supplies*<br><br><u>Enteral Formula:</u><br>Administered via feeding tube* or as a liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be metabolized. Individuals must meet medically necessary criteria.<br><br>Enteral formulas are ordered by practitioners and dispensed by pharmacy. May be administered as a Home Infusion service. | Plan pays 100%.<br><br>If provided in conjunction with Home Infusion Visit. | N | Plan pays 80%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | Y |
| *PKU Food Supplements* | Covered under Pharmacy Benefit. | N | Covered under Pharmacy Benefit. | N |
| **OFFICE VISITS** | | | | |
| *Primary* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| *Specialist* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| **ORTHOTICS** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Orthotics*<br>*Removable shoe inserts are NOT covered. For all other orthotics please refer to the P&A benefit* | Plan pays 80% | N | Plan pays 50%<br>After Deductible. | Y |
| **OSTOMY SUPPLIES** | | | | |
| *Ostomy Supplies* | Plan pays 80% | N | Plan pays 50%<br>After Deductible. | N |
| **OUTPATIENT SURGICAL PROCEDURES** | | | | |
| *Facility* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | Y |
| *Physician/Provider –*<br>*Facility Based* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | N |
| *Physician/Provider –*<br>*Office Based* | Plan pays 100%<br>After Office Visit copay. | N | Plan pays 80%<br>After Deductible. | Y |
| **PHYSICIAN/PROVIDER VISIT -INPATIENT** | | | | |
| *Physician/Provider Visit -Inpatient* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | N |
| **PODIATRY**<br>**TREATMENT OF INJURIES AND DISEASES OF THE FEET (SUCH AS HAMMER TOE OR HEEL SPURS).**<br>**ROUTINE FOOT CARE FOR COVERED PERSONS WITH CERTAIN MEDICAL CONDITIONS AFFECTING THE LOWER LIMBS.** | | | | |
| *Facility –*<br>*Outpatient* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| *Podiatrist –*<br>*Facility Outpatient Based* | Plan pays 100%. | N | Plan pays 80%<br>After Deductible. | N |
| *Podiatrist –*<br>*Office Based Surgical Procedures* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| *Podiatrist –*<br>*Office Visit (E&M)* | Plan pays 100%<br>After $10 copay. | N | Plan pays 80%<br>After Deductible. | N |
| **PROSTHETICS AND APPLIANCES (P&A)** | | | | |
| *Prosthetics and Appliances (P&A)* | Plan pays 80% | N | Plan pays 50%<br>After Deductible. | Y |
| **PULMONARY REHAB**<br>**(LIMIT 24 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Pulmonary Rehab* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | Y |
| **RADIATION THERAPY** | | | | |
| *Professional Services* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Technical Services* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| **RADIOLOGY (X-RAYS)** | | | | |
| *Routine X-rays Technical Services* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Routine X-rays Professional Services* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Advanced Radiology Technical Services*<br><br>*Advanced Radiology Services includes:MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Advanced Radiology Professional Services* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **REVERSAL OF ELECTIVE STERILIZATION – NOT COVERED** | | | | |
| **ROUTINE PHYSICALS** | | | | |
| *Routine Physicals (19 years & older)* | Plan pays 100%. | N | Not Covered. | N |
| **SCOPES** | | | | |
| *Facility – Outpatient* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Physician – Facility Outpatient Based* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Physician – Office Based Scope Procedures* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| **SKILLED NURSING FACILITY (SUB-ACUTE)** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Facility (Limit of 45 days per plan year)* | Plan pays 100% | N | Plan pays 80% After Deductible. | Y |
| *Physician/ Ancillary Visits* | Plan pays 100% | N | Plan pays 80% After Deductible. | N |
| **SLEEP STUDIES** | | | | |
| *Sleep Studies* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| **SMOKING CESSATION** | | | | |
| *Smoking Cessation Counseling and Intervention* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **TERMINATION OF PREGNANCY** | | | | |
| *Facility* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Physician/Provider – Facility Based* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Physician/Provider – Office Based* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| **TMJ TREATMENT** | | | | |
| *TMJ Treatment* | Coverage is based on services rendered. | Y | Plan pays 80% After Deductible. | Y |
| **THERAPIES – OUTPATIENT (UP TO 20 VISITS PER PLAN YEAR COMBINED)** | | | | |
| *Physical Therapy* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Occupational Therapy* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Speech Therapy* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| **TRANSPLANTS** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Donor (donates the organ)* | Claims need to be submitted to the donor's insurance company. An EOB from the other 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.<br><br>Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.<br><br>Member liability based on services rendered. | N | Claims need to be submitted to the donor's insurance company. An EOB from the other 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.<br><br>Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.<br><br>Member liability based on services rendered. | Y |
| *Recipient (receives the organ)* | Recipient must be a covered person of IH.<br><br>Member liability based on services rendered. | N | Plan pays 80% After Deductible.<br><br>Recipient must be a covered person of IH. | Y |
| **TUBAL LIGATION** | | | | |
| *Facility* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Physician – Facility Based* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| **URGENT CARE**<br>**IF COVERED PERSON RECEIVES URGENT CARE IN THE EMERGENCY ROOM, THE ER COPAY APPLIES.** | | | | |
| *In-Area (Providers Office)* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| *Participating Urgent Care Center* | Plan pays 100% After $35 copay. | N | See Urgent Care Out-of-Area. | 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). | Y | Plan pays 80% After Deductible<br><br>If member fails to pre certify.<br><br>Covered as In-Network if member does pre certify. | Y |
| **VASECTOMY** | | | | |

| ENCOMPASS B (10/20/35, 7/15/30,7/25/40,7/20/40) | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Facility* | Plan pays 100% After $10 copay. | N | Plan pays 80% After Deductible. | N |
| *Physician – Facility Based* | Plan pays 100%. | N | Plan pays 80% After Deductible. | N |
| *Physician – Office Based* | Plan pays 100% After Office Visit copay. | N | Plan pays 80% After Deductible. | N |
| **WELL BABY/CHILD CARE** | | | | |
| **Well Baby/Child Care** *(0-18 years)* AAP-American Academy of Pediatrics | Covered in Full up to age 19 according to AAP guidelines. | N | Plan pays 80% After Deductible. | N |

| BRONZE PLAN | | |
|---|---|---|
| **Benefit Description** | **In-Network** | **Out-of-Network** |
| **Deductible** | $5,000 Individual<br>$10,000 Family<br><br>The combined deductible applies to covered in network or out-of-network medical services (unless preventive) and does apply to any applicable pharmacy coverage.<br><br>On an Individual policy, the individual combined deductible must be met before IH provides reimbursement for covered in-network or out-of-network services.<br><br>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. | |
| **Out-of-Pocket Maximum** | $6,350 Individual<br>$12,700 Family<br><br>Pharmacy OOP max shared with medical.<br><br>The in-network deductible, copayments and coinsurance apply to the in-network out-of-pocket max.<br><br>Any applicable pharmacy member liability applies to the in-network out-of-pocket max.<br><br>On a Single policy, the individual in-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network services, including pharmacy services.<br><br>On a Family policy, once a family member meets the individual in-network out-of-pocket max IH will provide 100% reimbursement of the allowed amount for covered in-network services, including pharmacy services. However, additional family members must satisfy the family in-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered in-network services, including pharmacy services.<br><br>Note: Once the in-network out-of-pocket max is met, the member will not be responsible for any in-network deductible, copayments or coinsurance including any applicable Rx member liability. | $10,000 Individual.<br>$20,000 Family,<br><br>The out-of-network copayments and coinsurance only apply to the out-of-network out-of-pocket max.<br><br>On a Single policy, the individual out-of-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered out-of-network services.<br><br>On a Family policy, once a family member meets the individual out-of-network out-of-pocket max, the out-of-pocket max is satisfied for that member. However, additional family members must satisfy the family out-of-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered out-of-network services.<br><br>Note: Once the out-of-network out-of-pocket max is met, the member will not be responsible for any out-of-network deductible, copayments or coinsurance. |
| **Coinsurance** | 20% unless otherwise noted | 40% unless otherwise noted |

| | | |
|---|---|---|
| Usual, Customary and Reasonable Rate | Not applicable | 90th Percentile.<br>Covered Person may be balanced billed for the difference between UCR and billed charges. If UCR rate is not available and IH cannot negotiate a rate, billed charges apply |
| Pre-certification | **Call Independent Health's Utilization Management Department at (716) 631-2661 or (800) 257-2753.** | |
| Penalty for Failure to Pre-Certify | N/A | 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.<br>The member is responsible for the payment of 50% of the eligible expenses up to a maximum of $500 for each admission/outpatient service. Additional payments may apply.<br>This additional percentage is a PENALTY and does not apply to the out-of-pocket maximum, deductible, and coinsurance. |
| Coordination Of Benefits Procedures | Refer to the Coordination of Benefits Section in the SPD for details. | |
| PCP Required? | Not required | |

| **BRONZE PLAN** | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **ACUPUNCTURE – NOT COVERED** | | | | |
| **ALCOHOL/SUBSTANCE ABUSE (ACUTE CONDITIONS ONLY)** | | | | |
| *Inpatient Facility Detox Only* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| *Inpatient Rehabilitation Facility* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| *Inpatient Rehabilitation Physician* | Plan pays 100% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Outpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Family Therapy* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Residential Treatment* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **ALLERGY TESTING & TREATMENT** | | | | |
| *Allergy Testing & Treatment* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Allergy Serum* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Rast Testing* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **AMBULANCE** | | | | |
| *Ambulance* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |
| **ANESTHESIA** | | | | |
| *Inpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Outpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Pain Management* | See Outpatient Surgical Procedures | | | |
| **ARTIFICIAL INSEMINATION** | | | | |
| *Artificial Insemination* | Not Covered. | N | Not Covered. | N |
| **ASSISTANT SURGEON** | | | | |
| *Inpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Outpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **AUTISM** | | | | |
| *Assessment for Autism* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Applied Behavioral Analysis (ABA)* | Not Covered. | N | Not Covered. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *ABA Treatment* | Not Covered. | N | Not Covered. | N |
| *Assistant Communication Devices (ACD)* | Not Covered. | N | Not Covered. | N |
| **AUTOLOGOUS BLOOD** | | | | |
| *Autologous Blood* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **CARDIAC REHABILITATION (LIMIT 24 VISITS PER EVENT. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |
| *Cardiac Rehabilitation* | Plan pays 80%<br>After Deductible.<br><br>Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction. | N | Plan pays 60%<br>After Deductible.<br><br>Covered following a heart transplant, Congestive Heart Failure, bypass surgery or a myocardial infarction. | N |
| **CHEMOTHERAPY TREATMENT (CANCER)** | | | | |
| *Chemotherapy Treatment (Cancer)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **CHIROPRACTIC CARE** | | | | |
| *Chiropractic Care* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **CONTRACEPTIVES** | | | | |
| *Contraceptives administered in the provider's office* | Devices dispensed in the office covered in full as a Medical benefit.<br><br>For insertion, removal or fitting of device, Plan pays 100% after:<br><br>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: Plan pays 80% after deductible<br><br>Implanon – must be obtained through a Specialty Pharmacy, covered in full. The specialty pharmacy dispensing program for these devices is no longer mandatory. | N | Devices/injections dispensed in the office covered as a Medical benefit. Plan pays 60% after Deductible.<br><br>For insertion, removal or fitting of device, Plan pays 60% after Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Contraceptive Injectable* | Injections administered in the office: Plan pays 100%<br><br>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 Plan pays 80% after deductible. | N | Plan pays 60% After Deductible. | N |
| *Contraceptives self-administered/used by the member* | See Pharmacy Benefit | N | See Pharmacy Benefit | N |
| **COSMETIC SURGERY** | | | | |
| *Cosmetic Surgery* | Not covered unless for reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved body part.<br><br>Member liability based on services rendered when deemed medically necessary. | Y | Not covered unless for reconstructive Surgery when incidental to or when it follows Surgery resulting from trauma, infection or other diseases of the involved body part.<br><br>Member liability based on services rendered when deemed medically necessary. | Y<br><br>Failure to pre-certify will result in denial to the Covered Person |
| **DENTAL** | | | | |
| *Preventive and Routine* | Not Covered | N | Not Covered | N |
| *Accidental Dental* | Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within twelve months of the accident.<br><br>Member liability based on services rendered when deemed medically necessary. | N | Covered as In-Network Benefit | N |
| *Congenital Disease and Anomaly* | Member liability based on services rendered when deemed medically necessary. | N | Member liability based on services rendered when deemed medically necessary. | Y |
| **DIABETIC** | | | | |
| *Insulin, Oral Agent (30 Day Supply)* | Plan pays 80% After Deductible or RX liability whichever is less. | N | Plan pays 60% After Deductible. | N |
| *Diabetic Supplies (30 Day Supply)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Diabetic Equipment (e.g. Blood Glucose Monitor)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Diabetic Equipment Insulin Pump* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Diabetic Teaching* | Plan pays 100%. | N | Plan pays 60% After Deductible. | N |
| *Diabetic Shoes and Inserts* | Not Covered | N | Not Covered | N |
| **DIAGNOSTIC TESTING** | | | | |
| *Diagnostic Testing (e.g. EKG, Stress Tests, not Lab or X-rays)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **DIALYSIS** | | | | |
| *Outpatient Facility* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Outpatient Physician* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **DURABLE MEDICAL EQUIPMENT (DME)** | | | | |
| *Durable Medical Equipment (DME)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **ELECTROCONVULSIVE THERAPY (ECT) - SEE MENTAL HEALTH** | | | | |
| **EMERGENCY CARE** | | | | |
| *Emergency Room Facility - also see Urgent Care* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |
| *ER Physician/Provider* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |
| *ER Follow up Visit* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |
| *Observation Beds – Facility* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |
| *Observation Beds – Physician* | Plan pays 80% After Deductible. | N | Covered as In-Network Benefit | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **HEARING** | | | | |
| *Hearing Tests* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Evaluation and Fitting for Hearing Aids* | Not Covered | N | Not Covered | N |
| *Hearing Aids* | Not Covered<br><br>Exception: Cochlear Implant and Bone Anchored Hearing Aid BAHA. Only FDA approved devices are covered. | N | Not Covered<br><br>Exception: Cochlear Implant and Bone Anchored Hearing Aid BAHA. Only FDA approved devices are covered. | N |
| **HOME HEALTH CARE/ AIDE (LIMIT 40 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |
| *Home Health Care/ Aide*<br>*1 Home Health Aide visit = up to 4 continuous hours* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| *Private Duty Nursing* | Not Covered | N | Not Covered | N |
| **HOME INFUSION THERAPY (FOR ENTERNAL AND PARENTERAL SEE NUTRITIONAL SUPPLIES)** | | | | |
| *Nursing Services/Visits* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| *Medication* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| *Other Services (e.g. supplies and per diem items)* | Plan pays 80%<br>After Deductible. | N | Plan pays 80%<br>After Deductible. | Y |
| **HOME VISITS** | | | | |
| *Home Visits (other than Home Health Care or Home Infusion Therapy)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **HOSPICE (INCLUDES BEREAVEMENT COUNSELING)** | | | | |
| *Advance Care Planning*<br>*(this benefit includes the Caring Hearts Perinatal Program)* | Plan pays 80%<br>After Deductible.<br><br>Limit 6 visits<br>Per Calendar Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N | Plan pays 60%<br>After Deductible.<br><br>Limit 6 visits<br>Per Calendar Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Inpatient* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Outpatient (Home)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **HOSPITAL** | | | | |
| *Hospital –<br>Inpatient Facility* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| *Hospital -<br>Inpatient Medical Rehab Facility* | Plan pays 80%<br>After Deductible.<br><br>Limit 45 days<br>Per Plan Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | N | Plan pays 60%<br>After Deductible.<br><br>Limit 45 days<br>Per Plan Year<br><br>In-network plus Out-of-Network services combined equal the total benefit. | Y |
| **IMMUNIZATIONS (IF DONE IN CONJUNCTION WITH AN OFFICE VISIT, THEN OFFICE VISIT COPAY MAY APPLY)** | | | | |
| *Adult Immunizations<br>(19 years and over)* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| *Flu & Pneumonia Immunizations<br>(19 years and over)* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| *Hepatitis B Immunizations<br>(19 years and over)* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| *Travel Immunizations<br>(19 years and over)* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| *Well Child Immunizations<br>(0-18 years)<br><br>ACIP = Advisory Committee for Immunization Practices* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| **INFERTILITY** | | | | |
| *Infertility* | Not Covered. | N | Not Covered. | N |
| **INJECTIONS** | | | | |
| *Injections – Office-Based (not self-administered)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **LABORATORY & PATHOLOGY** | | | | |
| *Laboratory & Pathology* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **MAMMOGRAMS** | | | | |
| *Professional Services* | Plan pays 100%. | N | Plan pays 60%<br>After Deductible. | N |
| *Technical Services* | Plan pays 100%. | N | Plan pays 60%<br>After Deductible. | N |
| **MASTECTOMY/POST-MASTECTOMY** | | | | |
| *Breast Prosthesis* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Post Mastectomy Supplies (Bras)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Reconstructive Surgery* | See Hospital and Outpatient Surgical Benefit. | N | See Hospital and Outpatient Surgical Benefit. | N |
| **MATERNITY CARE** | | | | |
| *Breast Feeding/ Lactation Support* | Plan pays 100%. | N | Plan pays 60%<br>After Deductible. | N |
| *Prenatal & Postnatal Visits*<br><br>*Note: If a visit is unrelated to Pregnancy, Covered Person liability may apply based on services rendered.* | Plan pays 100%<br>After initial Diagnosis | N | Plan pays 60%<br>After Deductible. | N |
| *Sonogram(s)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Facility – Delivery* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Facility – Physician* | Plan pays 100%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Newborn – Facility* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Newborn – Physician* | Plan pays 100%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |

| BRONZE PLAN | | | | |
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| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Home Visit (Resulting from early discharge)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Home Birth (Per Independent Health guidelines)* | Plan pays 100% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **MEDICAL SUPPLIES** | | | | |
| *Medical Supplies* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **MEDICAL EXPENDABLE SUPPLIES** | | | | |
| *Medical Expendable Supplies* | Plan pays 80% After Deductible.<br><br>When in conjunction with authorized skilled nursing services in the home | N | Plan pays 60% After Deductible.<br><br>When in conjunction with authorized skilled nursing services in the home | Y |
| **MENTAL HEALTH** | | | | |
| *Electroconvulsive Therapy (ECT) (e.g. Shock Therapy) Facility Outpatient Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Electroconvulsive Therapy(ECT) (e.g. Shock Therapy) Physician/Provider Outpatient Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit.* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Mental Health Inpatient Facility* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| *Mental Health Inpatient Physician/Provider* | Plan pays 100% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Mental Health Outpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Mental Health Partial Hospitalization*<br><br>*Care that is provided in lieu of inpatient mental health hospitalization at an approved facility* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| *Pharmacological (chemotherapy) Management*<br><br>*A brief interaction between a psychiatrist and a member for the primary purpose of reviewing medications and issuing a prescription with minimal psychotherapy* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Residential Treatment*<br><br>*Intensive Residential Rehabilitation Services are Residential Services requiring 24/7 treatment in a structured environment.*<br><br>*Note: Community Residential Services and Supportive Living Services are NOT covered.* | Plan pays 80%<br>After Deductible. | N | Plan pays 80%<br>After Deductible. | Y |
| **MRI & MRA – SEE RADIOLOGY SERVICES (ADVANCED)** | | | | |
| **NUTRITIONAL COUNSELING** | | | | |
| *Nutritional Counseling* | Plan pays 100% | N | Plan pays 60%<br>After Deductible. | N |
| **NUTRITIONAL SUPPLIES** | | | | |
| *Enteral & Parenteral Pumps* | See DME Benefit | N | See DME Benefit | N |
| *Parenteral Nutritional Supplies*<br><br><u>Parenteral Nutrition</u><br>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. | Plan pays 80%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | N | Plan pays 60%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | Y |
| *Enteral Formula & Supplies*<br><br><u>Enteral Formula:</u><br>Administered via feeding tube* or as a liquid oral nutritional therapy when there is a documented diagnostic condition where caloric and dietary nutrients from food cannot be metabolized. Individuals must meet medically necessary criteria.<br><br>Enteral formulas are ordered by practitioners and dispensed by pharmacy. May be administered as a Home Infusion service. | Plan pays 80%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | N | Plan pays 60%<br>After Deductible.<br><br>If provided in conjunction with Home Infusion Visit. | Y |
| *PKU Food Supplements* | Covered under Pharmacy Benefit. | N | Covered under Pharmacy Benefit. | N |
| **OFFICE VISITS** | | | | |
| *Primary* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |

| BRONZE PLAN | | | | |
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| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Specialist* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **ORTHOTICS** | | | | |
| *Orthotics*<br>*Removable shoe inserts are NOT covered. For all other orthotics please refer to the P&A benefit* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| **OSTOMY SUPPLIES** | | | | |
| *Ostomy Supplies* | Plan pays 80%<br>After Deductible. | N | Plan pays 50%<br>After Deductible. | N |
| **OUTPATIENT SURGICAL PROCEDURES** | | | | |
| *Facility* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | Y |
| *Physician/Provider – Facility Based* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Physician/Provider – Office Based* | Plan pays 100%<br>After Office Visit copay. | N | Plan pays 60%<br>After Deductible. | Y |
| **PHYSICIAN/PROVIDER VISIT -INPATIENT** | | | | |
| *Physician/Provider Visit -Inpatient* | Plan pays 100%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **PODIATRY**<br>**TREATMENT OF INJURIES AND DISEASES OF THE FEET (SUCH AS HAMMER TOE OR HEEL SPURS).**<br>**ROUTINE FOOT CARE FOR COVERED PERSONS WITH CERTAIN MEDICAL CONDITIONS AFFECTING THE LOWER LIMBS.** | | | | |
| *Facility – Outpatient* | Plan pays 80%<br>After Deductible. | N | Plan pays 80%<br>After Deductible. | N |
| *Podiatrist – Facility Outpatient Based* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Podiatrist – Office Based Surgical Procedures* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Podiatrist – Office Visit (E&M)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **PROSTHETICS AND APPLIANCES (P&A)** | | | | |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Prosthetics and Appliances (P&A)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **PULMONARY REHAB (LIMIT 24 VISITS PER PLAN YEAR. IN-NETWORK PLUS OUT-OF-NETWORK SERVICES COMBINED EQUALS THE TOTAL BENEFIT)** | | | | |
| *Pulmonary Rehab* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| **RADIATION THERAPY** | | | | |
| *Professional Services* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Technical Services* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **RADIOLOGY (X-RAYS)** | | | | |
| *Routine X-rays Technical Services* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Routine X-rays Professional Services* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Advanced Radiology Technical Services*<br><br>*Advanced Radiology Services includes:MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Advanced Radiology Professional Services* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **REVERSAL OF ELECTIVE STERILIZATION - NOT COVERED** | | | | |
| **ROUTINE PHYSICALS** | | | | |
| *Routine Physicals (19 years & older)* | Plan pays 100%. | N | Not Covered. | N |
| **SCOPES** | | | | |
| *Facility – Outpatient* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Physician – Facility Outpatient Based* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |

| BRONZE PLAN | | | | |
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| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Physician – Office Based Scope Procedures* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **SKILLED NURSING FACILITY (SUB-ACUTE)** | | | | |
| *Facility (Limit of 60 days per plan year)* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | Y |
| *Physician/ Ancillary Visits* | Plan pays 100% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **SLEEP STUDIES** | | | | |
| *Sleep Studies* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **SMOKING CESSATION** | | | | |
| *Smoking Cessation Counseling and Intervention* | Plan pays 100%. | N | Plan pays 60% After Deductible. | N |
| **TERMINATION OF PREGNANCY** | | | | |
| *Facility* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Physician/Provider – Facility Based* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| *Physician/Provider – Office Based* | Plan pays 80% After Deductible. | N | Plan pays 60% After Deductible. | N |
| **TMJ TREATMENT** | | | | |
| *TMJ Treatment* | Coverage is based on services rendered. | Y | Plan pays 80% After Deductible. | Y |
| **THERAPIES—OUTPATIENT (UP TO 20 VISITS PER PLAN YEAR COMBINED)** | | | | |
| *Physical Therapy* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |
| *Occupational Therapy* | Plan pays 100% After $15 copay. | N | Plan pays 80% After Deductible. | N |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| *Speech Therapy* | Plan pays 100%<br>After $15 copay. | N | Plan pays 80%<br>After Deductible. | N |
| **TRANSPLANTS** | | | | |
| *Donor*<br>*(donates the organ)* | Claims need to be submitted to the donor's insurance company. An EOB from the other 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.<br><br>Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.<br><br>Member liability based on services rendered. | N | Claims need to be submitted to the donor's insurance company. An EOB from the other 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.<br><br>Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered.<br><br>Member liability based on services rendered. | Y |
| *Recipient*<br>*(receives the organ)* | Recipient must be a covered person of IH.<br><br>Member liability based on services rendered. | N | Plan pays 60%<br>After Deductible.<br><br>Recipient must be a covered person of IH. | Y |
| **TUBAL LIGATION** | | | | |
| *Facility* | Plan pays 100%. | N | Plan pays 60%<br>After Deductible. | N |
| *Physician –*<br>*Facility Based* | Plan pays 100%. | N | Plan pays 60%<br>After Deductible. | N |
| **URGENT CARE**<br>**IF COVERED PERSON RECEIVES URGENT CARE IN THE EMERGENCY ROOM, THE ER COPAY APPLIES.** | | | | |
| *In-Area*<br>*(Providers Office)* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Participating Urgent Care Center* | Plan pays 80%<br>After Deductible. | N | See Urgent Care<br>Out-of-Area. | 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). | Y | Plan pays 60%<br>After Deductible<br><br>If member fails to pre certify.<br><br>Covered as In-Network if member does pre certify. | Y |

| BRONZE PLAN | | | | |
|---|---|---|---|---|
| **Benefit Description** | **IN-NETWORK (Participating)** | **Member Precertification Required** | **OUT-OF-NETWORK (Non-Participating)** | **Member Precertification Required** |
| **VASECTOMY** | | | | |
| *Facility* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Physician – Facility Based* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| *Physician – Office Based* | Plan pays 80%<br>After Deductible. | N | Plan pays 60%<br>After Deductible. | N |
| **WELL BABY/CHILD CARE** | | | | |
| **Well Baby/Child Care**<br>*(0-18 years)*<br><br>AAP-American Academy of Pediatrics | Covered in Full<br>up to age 19 according to AAP guidelines. | N | Not Covered | N |

| PPO OOA PLAN | | |
|---|---|---|
| **Benefit Description** | **In-Network** | **Out-of-Network** |
| **Deductible** | $500 Individual<br>$1,000 Family<br><br>The in-network deductible applies to covered in-network medical services (unless preventive) and does NOT apply to any applicable pharmacy coverage.<br><br>On a Single policy, the individual in-network deductible must be met before IH provides reimbursement for covered in-network services.<br><br>On a Family policy, once a family member meets the individual in-network deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family in-network deductible before IH provides reimbursement for covered in-network services. | $2,500 per Individual<br>$5,000 per Family<br><br>The out-of-network deductible applies to covered out-of-network medical services and does NOT apply to any applicable pharmacy coverage.<br><br>On a Single policy, the individual out-of-network deductible must be met before IH provides reimbursement for covered out-of-network services.<br><br>On a Family policy, once a family member meets the individual out-of-network deductible, the deductible is satisfied for that member. However, additional family members must satisfy the family out-of-network deductible before IH provides reimbursement for covered out-of-network services. |
| **Out-of-Pocket Maximum** | $2,000 Individual<br>$4,000 Family<br><br>Pharmacy OOP max:<br>Single $4,600/Family $9,200 not shared with medical.<br><br>The in-network deductible, copayments and coinsurance apply to the in-network out-of-pocket max.<br><br>On a Single policy, the individual in-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network services, including pharmacy services. | $6,600 per Individual<br>$13,700 per Family<br><br>On a Single policy, the individual out-of-network out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered out-of-network services.<br><br>On a Family policy, once a family member meets the individual out-of-network out-of-pocket max, the out-of-pocket max is satisfied for that member. However, additional family members must satisfy the family out-of-network out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered out-of-network services. |