**Account Name: Williamsville Teachers' Assoc.**
**Account #: 34420**
**Plan Effective Date: January 1, 2021**

Independent Health
SELF-FUNDED SERVICES

**Group Name:** Williamsville Teachers Association

| Benefit Summary | Health Plan | | |
|---|---|---|---|
| | Active | Family | Additional Information |
| **General Information** | | | |
| Deductible | In-Network: $0<br>Out-of-Network:<br>$1,000/$2,000 | In-Network: $0<br>Out-of-Network:<br>$1,000/$2,000 | Where deductible applies it accumulates as embedded.<br>*See important notes section for more detail. |
| Coinsurance | In-Network: Applies Where Indicated<br>Out-of-Network: 20% | In-Network: Applies Where Indicated<br>Out-of-Network: 20% | |
| Out-of-Pocket Maximum | In-Network: $7,150 /$14,300<br>Out-of-Network<br>$10,000/$20,000 | In-Network: $7,150 /$14,300<br>Out-of-Network<br>$10,000/$20,000 | Where out-of-pocket applies it accumulates as embedded<br>*See important notes section for more detail. |
| Annual Maximum | Not Applicable | Not Applicable | |
| **Preventive Services** | | | |
| Bone mineral density measurements or tests<br>Cholesterol test (lipid panel)<br>Colonoscopy and Sigmoidoscopy<br>Contraceptives Drugs, Devices and Counseling<br>Immunizations<br>Mammogram<br>Pap Smear<br>Physical Exam<br>Prenatal and Post-partum Visits<br>Prostate test (Prostate Specific Antigen "PSA")<br>Well child visit<br>Well Woman Visit | $0 | $0 | All preventive services are covered in full with $0 member liability when performed by a participating provider. See independenthealth.com for additional information. |
| **Physician and Other Services** | | | |
| Primary Office Visit | Adults: $10 copay / visit<br>Children: $25 copay / visit | Adults: $15 copay / visit<br>Children: $0 copay / visit | PCP Required |
| Specialist Office Visit | Adults: $25 copay / visit<br>Children: $25 copay / visit | Adults: $25 copay / visit<br>Children: $25 copay / visit | |
| Allergy Testing & Treatment | Adults: $10/$25 copay / visit<br>Children: $25 copay / visit | Adults: $15/$25 copay / visit<br>Children: $0/$25 copay / visit | |
| Outpatient Surgical Procedures (in physician's office) | Adults: $10/$25 copay / visit<br>Children: $25 copay / visit | Adults: $15/$25 copay / visit<br>Children: $0/$25 copay / visit | |
| **Emergency & Urgent Care Services** | | | |
| Emergency Room | $150 copay / visit | $150 copay / visit | Waived if admitted |
| Ambulance | $150 copay/trip | $150 copay/trip | Must be deemed medically necessary |
| Urgent Care Center | $75 copay / visit | $75 copay / visit | |
| **Hospital and Other Facility Services** | | | |
| Inpatient Hospital | $0 copay / admission | $0 copay / admission | Semi-private room, per admission |
| Inpatient Hospital: Physician/Surgeon Fees | $0 copay / visit | $0 copay / visit | |
| Inpatient Hospice | $0 copay / admission | $0 copay / admission | |
| Outpatient Surgical Procedures (Facility) | $150 copay / visit | $125 copay / visit | |
| Outpatient Surgical Procedures (Facility) Physician/Surgeon Fees | $0 copay / visit | $0 copay / visit | |
| Skilled Nursing Facility | $0 copay / admission | $0 copay / admission | Semi-private room, per admission<br>Up to 45 days per contract year |

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| **Diagnostic Testing Services** | | | |
| Laboratory Testing | $0 copay / visit | $0 copay / visit | |
| EKG | Adults: $10/$25 copay / visit<br>Children: $25 copay / visit | Adults: $15/$25 copay / visit<br>Children: $0/$25 copay / visit | |
| Routine Radiology | $25 copay / visit | $25 copay / visit | |
| Advanced Radiology | $75 copay / visit | $75 copay / visit | Radiology services, other than X-rays, included but not limited to MRI, MRA, CT Scans, myocardial perfusion Imaging and PET Scans. Annual maximum copayment of $750 |
| **Maternity Services** | | | |
| Physician Services: Prenatal and Postnatal Care | Adults: $0 copay / visit<br>Children: $0 copay / visit | Adults: $0 copay / visit<br>Children: $0 copay / visit | No charge after the initial diagnosis |
| Inpatient Maternity | Delivery: $0 copay / admission<br>Physician: $0 copay / procedure | Delivery: $0 copay / admission<br>Physician: $0 copay / procedure | Semi-private room, per admission |
| **Mental Health & Substance Abuse** | | | |
| Inpatient Mental Health | $0 copay / admission | $0 copay / admission | Semi-private room, per admission |
| Outpatient Mental Health | Adults: $10 copay / visit<br>Children: $0 copay / visit | Adults: $15 copay / visit<br>Children: $0 copay / visit | |
| Inpatient Substance Abuse - Rehab | $0 copay / admission | $0 copay / admission | Semi-private room, per admission |
| Inpatient Substance Abuse - Detox | $0 copay / admission | $0 copay / admission | Semi-private room, per admission |
| Outpatient Substance Abuse | Adults: $10 copay / visit<br>Children: $0 copay / visit | Adults: $15 copay / visit<br>Children: $0 copay / visit | |
| **Diabetic Supplies and Services** | | | |
| Diabetic Equipment (e.g. Blood glucose monitor, etc.) | $10 copay | $15 copay | |
| Insulin and Other Oral Agents | $10 copay | $15 copay | Office visit copay or pharmacy rider copay, whichever is less |
| Diabetic Medical Supplies (Test Strips, Syringes, etc.) | $10 copay | $15 copay | |
| **Rehabilitation Services** | | | |
| Chiropractic Services | $25 copay / visit | $25 copay / visit | |
| Physical-Occupational-Speech Therapies | $25 copay / visit | $25 copay / visit | Up to 20 visits per contract year |
| Cardiac Rehabilitation | $25 copay / visit | $25 copay / visit | Up to 36 visits per event |
| Pulmonary Rehabilitation | $25 copay / visit | $25 copay / visit | Up to 24 visits per contract year |
| **Additional Services** | | | |
| Durable Medical Equipment | 20% coinsurance | 20% coinsurance | |
| Prosthetics and Appliances | 20% coinsurance | 20% coinsurance | |
| Chemotherapy | Adults: $10/$25 copay / visit<br>Children: $25 copay / visit | Adults: $15/$25 copay / visit<br>Children: $0/$25 copay / visit | |
| Home Health Care | $25 copay / visit | $25 copay / visit | Up to 40 visits per contract year |
| Unique Benefits | $250 allowance | $250 allowance | To be used to pay for eligible health & wellness activities at participating Health Extras vendors |

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| **Prescription Drug Services** | | | |
| Prescription Plan | $3/$15/$30 | $3/$15/$30 | Must be filled at a participating pharmacy. |
| Maintenance Medications | 2.5 copays for a 3 month supply | 2.5 copays for a 3 month supply | Mail order must be obtained by ProAct or Wegmans. Retail pharmacy must be filled at a participating Pharmacy. |
| **Vision Services** | | | |
| Medical Eye Exam | $25 copay / visit | $25 copay / visit | |
| Routine Refractive Exam | $10 copay / visit | $10 copay / visit | Once every 12 months |
| Standard Plastic Lenses | Single: $50<br>Bifocal: $70 | Single: $50<br>Bifocal: $70 | Contact Eyemed for additional options at 1-877-842-3348 |
| Frames | 40% discount | 40% discount | Discount is based on retail pricing |
| Conventional Contact Lenses | 15% discount | 15% discount | Materials only |
| Laser Vision Correction | 50% discount | 50% discount | Up to $300 maximum |
| **Dental Services** | | | |
| Preventive and Routine | Not Covered | Not Covered | |
| Accidental Dental | Based on services rendered | Based on services rendered | Must be deemed medically necessary |
| **Dependent Coverage** | | | |
| Dependent Eligibility | 26 | 26 | Up to end of the birthday month |

**Important Notes**

Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.

Embedded: On a single policy, the single deductible/out-of-pocket max must be met before reimbursement is provided for covered in-network or out-of-network services. On a family policy, once a family member meets the single deductible/out-of-pocket maximum, the deductible/out-of-pocket maximum is satisfied for that member. However additional family members must satisfy the remainder of the deductible/out-of-pocket maximum before reimbursement for covered in-network or out-of-network services is provided.

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

Member Pre-Certification: Certain services and benefits are subject to member pre-precertification. Member is responsible for contacting Independent Health for pre-certification.

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

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