Independent Health
Dedicated to Making a Difference
511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

Group Name: Williamsville Teachers' Association

Benefit Summary	WTABT Health Plan Active	WTABT Health Plan Family	Additional Information
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal and one postpartum visit Prostate test (Prostate Specific Antigen "PSA") Well child visit Well Woman visit	$0	$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	Adult: $10 copay/visit Child: $25 copay/visit	Adult: $15 copay/visit Child: $0 copay/visit	
Specialist Office Visit	Adult: $25 copay/visit Child: $25 copay/visit	Adult: $25 copay/visit Child: $25 copay/visit	
Allergy Testing & Treatment	Adult: $10/$25 copay/visit Child: $25 copay/visit	Adult: $15/$25 copay/visit Child: $0/$25 copay/visit	
Outpatient Surgical Procedures (in physician's office)	Adult: $10/$25 copay/visit Child: $25 copay/visit	Adult: $15/$25 copay/visit Child: $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
Participating After Hours Care Centers	$75 copay/visit	$75 copay/visit	
Hospital 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 Up to 45 days per contract year
Diagnostic Testing Services			
Laboratory Testing	$0 copay/visit	$0 copay/visit	
EKG	Adult: $10/$25 copay/visit Child: $25 copay/visit	Adult: $15/$25 copay/visit Child: $0/$25 copay/visit	
Routine Radiology	$25 copay/visit	$25 copay/visit	

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Diagnostic Testing Services			
Advanced Radiology	$75 copay/visit	$75 copay/visit	Radiology services, other than X-rays, including 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	Adult: $0 copay/visit Child: $0 copay/visit	Adult: $0 copay/visit Child: $0 copay/visit	No charge after the initial diagnosis
Inpatient Maternity	Delivery: $0 copay/admission Physician: $0 copay/procedure	Delivery: $0 copay/admission 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	$25 copay/visit	Adults: $15 copay/visit Child: $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 Child: $25 copay/visit	Adults: $15 copay/visit Child: $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	
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	Adult: $10/$25 copay/visit Child: $25 copay/visit	Adult: $15/$25 copay/visit Child: $0/$25 copay/visit	

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Additional Services			
Home Health Care	$25 copay/visit	$25 copay/visit	Up to 40 visits per contract year
Unique Benefits	$250 allowance per subscriber, per contract year, for a membership to a participating fitness club including traditional gyms, health clubs and fitness centers for men and women, complimentary alternative therapies to include: acupuncture, massage therapy, dietary counseling, yoga, pilates, tai chi and vitamins and herbs	$250 allowance per subscriber, per contract year, for activities provided at family oriented fitness centers and other organizations. Can be used on fees associated with sports and fitness programs for children including swim lessons, gymnastics, tumbling, basketball, soccer, tennis lessons, karate, and baby sitting clinics as well as school activity programs and day camp	
Prescription Drug Coverage			
Prescription Plan	$3/$15/$30	$3/$15/$30	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary I.
Maintenance Medications	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply	Mail Order: Must be obtained from Walgreens 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 Bifocal: $70	Single: $50 Bifocal: $70	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% discount	40% discount	Discount is based on retail pricing

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Vision Services			
Conventional Contact Lenses	15% discount	15% discount	Materials only
Laser Vision Correction	50% discount	50% discount	Up to $400 maximum per eye
Dental Services			
Preventive and Routine	Not Covered	Not Covered	
Accidental Dental	Based on services rendered	Based on services rendered	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month
In-Network Information			
Deductible	Not Applicable	Not Applicable	
Coinsurance	Applies Where Indicated	Applies Where Indicated	
Out-of-Pocket Maximum	$6,350/$12,700	$6,350/$12,700	
Annual Maximum	Not Applicable	Not Applicable	
Lifetime Maximum	Not Applicable	Not Applicable	
Out-of-Network Information			
Deductible	$1,000/$2,000	$1,000/$2,000	
Coinsurance	20%	20%	
Out-of-Pocket Maximum	$10,000/$20,000	$10,000/$20,000	
Annual Maximum	Not Applicable	Not Applicable	
Lifetime Maximum	Not Applicable	Not Applicable	

Important Notes

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

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

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

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

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