This grid provides an overview of the Self-funded Services benefits selected by the Group listed below. It should only be used as a guide. For a complete listing of the Plan benefits and their specific provisions refer to the Group's Summary Plan Description.

Plan Name:	24522-First Choice HDHP HSA	
Group Name:	Kenmore-Town of Tonawanda Union Free School District	
Group Nos. and Benefit Package/ Plan(s):	**Group Number(s) & Corresponding Benefit Package/Plan(s):** 24522 **Grandfathered Plan - No**	
Group Addresses:	**Local Address:** 1500 Colvin Boulevard Buffalo, NY 14223	**Corporate Address:**
Group Contact Information: ***(Contact Names & Titles, Addresses, Phone Nos., Fax Nos., Email Addresses)***	Ronald L. Moser, Supervisor, Human Resources 716-874-8400 x5359 716-874-8546 rmoser@kenton.k12.ny.us	
Original Plan Effective Date:	7/1/2013 Contract Year – July to June Tax ID# 166002097	**Plan Amendment Date(s):** 7/1/14: • Nutritional Supplies – PKU food supplement pharmacy $2500 limit removed • Clinical Trials – Routine standard of care service • Residential treatment for alcohol/substance abuse and mental health 5/1/15: Updated 'N' to 'Y' in Physician Visit Inpatient Pre-Auth field. See authorization list for services requiring pre-auth. **7/1/15** • DME, P&A, Ostomy, Orthotics 80%/20% Coinsurance – In Network only • Revised Orthotics language as custom molded shoe inserts are the only item not covered • Separate Rx OOP $1600 Individual/$3200 Family • No Guest Membership **1/1/16** • ER copay $250 • Ambulance Copay $100 • Dialysis Outpatient – changed to deductible and $20 copay

		• Diabetic equipment/supplies – changed to CIF
Other Contact Information:	**Authorized to Access PHI:** Ron Moser, Kathy Kightlinger	**Claims Funding:** Same
		Out of Plan Payment Authorization: Ron Moser
	Account Servicing Representative:	**Sales Account Manager:** Nancy Porter
Broker Contact Information ***(Contact Names & Titles, Addresses, Phone Nos., Fax Nos., Email Addresses)***	William Brothers Premier Consulting Associates 2420 Sweet Home Road Suite 140 Amherst, New York 14228	
Tier Type:	**1**	**2** (circled) **3** **4** **Other**
Plan Design Based on :	First Choice HSA	

Who has this plan?					
Options	**First Choice Tier 1**	**Specialty Services**	**Non First Choice Tier 2**	**Par Physician and Ancillary (IHC Network)**	**Out of Network**
Deductible	$1250/$2500 Combined In and Out of Network The deductible is shared and applies to any applicable prescription coverage, as well as to any medical (unless preventive) services On a single policy, the individual deductible must be met before IH provides reimbursement for covered services. On a family policy, the family deductible must be met before IH provides reimbursement for covered services. An individual on a family policy will not stop at the individual deductible.				
Coinsurance			30%	See benefit.	30%
Out of Pocket	$5000 Individual (medical only) $10000 Family On a Single policy, the individual combined out-of-pocket max must be met before IH provides 100% reimbursement of the allowed amount for covered in-network or out-of-network services. On a Family policy, once a family member meets the individual combined out-of-pocket max IH will provide 100% reimbursement of the allowed amount for covered in-network and out-of-network services, including pharmacy services. However, additional family members must satisfy the family combined out-of-pocket max before IH provides 100% reimbursement of the allowed amount for covered in-network or out-of-network services. Note: Once the combined out-of-pocket max is met, the member will not be responsible for any in-network or out-of-network deductible, copayments or coinsurance. **Effective 7/1/15** **Separate Rx Out of Pocket** **$1600 Individual** **$3200 Family** **The deductible is shared between medical and Rx out of pocket max, but any copayments or coinsurance is split between the medical and Rx out-of-pocket max.**				
Out-of-Plan Authorization Provision					Applicable
UCR	Not Applicable				80th Percentile Members may be balance billed for the difference between UCR and billed charges. If UCR rate is not available and IH cannot negotiate a rate, billed charges

			apply. (Unless FIRST HEALTH – see below)
Penalty	In-Network N/A	Out of Network IH will pay only 50% of the lesser of the medically necessary, non-participating provider's charges, negotiated rate or UCR (Usual, Customary and Reasonable) rate for services. The covered person pays the balance, if any. The additional percentage is a penalty and does not apply to the out-of-pocket maximum, deductible or coinsurance limit.	
Preventive Services	Covered in full – in network Preventive Services Grid If a sick office visit (E & M) is billed, Covered Person liability is applied. **NOTE: Blood collection codes 36415 and 36416 (in-network only).** • **Preventive laboratory service only: Covered in full.** • **Combined preventive lab service with non-preventive lab service: Subject to laboratory member liability.** • **Non-preventive lab service: Subject to laboratory member liability.**		Not applicable
Effective Date	07/01/2013		
Plan Amendment Date	N/A		
Company	Self-Funded IHSFS		
Dependent Coverage Age Limitations	Covered up to the end of the month of the dependent's 26th birthday		
Open Enrollment Period			
Enrollment Transmission Format	❑834 ❑ Excel File x Paper		
Guest Membership	Not Applicable		
Primary Care Physician	Required to be on file. See specific benefit for provider pre-authorization requirements.		
Pre-existing Condition	Not Applicable		
No Control Clause	No Control means Independent Health's process to follow industry standards for non-participating/non-network Anesthesia services and Non-participating/non-network Provider inpatient services to be covered as an In-Network benefit when services are obtained at a participating/network Hospital or participating/network free standing Ambulatory Surgery Facility setting. Claims process as an in-network benefit when rendered by: a. Services provided by a Non-Participating anesthesiologist when the operating surgeon is a Participating Provider; b. Diagnostic laboratory and pathology tests referred to a Non-Participating laboratory or pathologist by a Participating Provider; or c. Consultation services by a Non-Participating Provider which are provided to you while you are confined as an inpatient at a Participating Hospital or other facility and the physician who requested the consultation is a Participating Provider.		
Appeals	1st Level: Independent Health 2nd Level: Independent Health 3rd Level/External:		
Medical Administrator			
Vision Administrator			
Prescription Administrator	IH PBD		

Mental Health/Substance Abuse Administrator					
Dental Administrator					
COBRA Administrator					
HSA Administrator	N/A				
FSA/HRA Administrator					
Non Par Timely Filing	One Year from DOS				
Provider Network	**First Choice Providers** • Kenmore Mercy • Mercy Hospital • Sisters • St. Joseph • Mt. St. Mary's • Bertrand Chaffee • Buffalo Surgery Center (On Excelsior Campus) • Windsong Radiology • Center for Ambulatory Surgery • Southtowns Radiology • Buffalo Ambulatory Center • Seton Imaging • Effective 06.01.14 Eastern Niagara Hospitals (Lockport Memorial and Intercommunity Newfane Hospital) • Effective 1/15/16 Medina Memorial Hospital • **List of Par CHS Facilities**	**Specialty Services** • Roswell (cancer treatment) • ECMC (Burns, Trauma, Transplants and MH/Sub Abuse) • Womens & Childrens Hospital (pediatric care) • Brylin (MH/Sub abuse)	**All other IHC par facilities** Some examples are: • Kaleida Hospitals • VNA Home Care	**Par IHC Physicians and Ancillary Providers** Some examples are: • Catholic Medical Partners • Buffalo Medical Group • Benson Surgical • Quest Diagnostics	Not Applicable **Note**: If the services provider is outside of the eight counties of WNY and is in the FIRST HEALTH network the member is only responsible for their applicable out-of-network member liability (deductible/coinsurance). IH will pay the FIRST HEALTH fee schedule and the member will not be balance billed the difference between the billed charges and FIRST HEALTH fee schedule. **Note**: If the servicing provider is in the eight counties of WNY and is in the FIRST HEALTH network the member is responsible for their applicable out-of-network member liability (deductible/coinsurance) and balance billing may apply. Per the FIRST HEALTH contract, their fee schedule cannot be applied.

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Acupuncture	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Alcohol/Substance Abuse (Acute Conditions Only)									
Inpatient Facility Detox Only	Subject to deductible then covered in full	Subject to deductible then a $250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year. **If admitted through ER,** Covered in full	Subject to deductible and 30% coinsurance **If admitted through ER,** Covered in full **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission does NOT apply.**	N/A	**Y**
Inpatient Rehabilitation Facility	N/A	Subject to deductible then a $250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year. **If admitted through ER,** Covered in full	Subject to deductible and 30% coinsurance **If admitted through ER,** Covered in full **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission does NOT apply.**	N/A	**Y**
Inpatient Rehabilitation Professional	N/A	N/A	N/A	Covered in full as long as medically necessary.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	**0-18:** Subject to deductible then $20 copayment	**0-18:** Subject to deductible then $20 copayment	Subject to deductible and 30% coinsurance.	**0-18:** Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	19 and over: Subject to deductible then $10 copayment.	**19 and over:** Subject to deductible then $10 copayment.		**19 and over:** Subject to deductible then $10 copayment.			apply.		
Family Therapy	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10 copayment.	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10 copayment.	Subject to deductible and 30% coinsurance.	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Residential Treatment ***Intensive Residential Rehabilitation Services*** *are Residential Services requiring 24/7 treatment in a structured environment.* ***Note****: Community Residential Services and Supportive Living Services are* ***NOT*** *covered.*	N/A	Subject to $250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year. **If admitted through ER,** Covered in full	Subject to deductible and 30% coinsurance **If admitted through ER,** Covered in full **Rapid readmission does NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission.	N/A	**Y**
Allergy Testing & Treatment	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10 copayment.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Allergy Serum	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Rast Testing	Covered in full	Covered in full	Subject to deductible and 30% coinsurance	**If member goes to an Independent Lab:** Subject to deductible and 30% coinsurance **If collected in a doctor's office and is sent out or processed in doctor's office:** Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Ambulance	N/A	N/A	N/A	Effective 1/1/16 Subject to deductible then $100 copayment Prior to 1/1/16, deductible then $25 copay when medically necessary. Wheelchair van transportation is not covered.	**Y** Planned Transportation N Emergency	N/A	Covered as an in-network benefit.	N/A	N/A
Anesthesia (Professional Services Only)									
Inpatient	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	N/A	N/A	N/A	Subject to deductible then covered in full	**Y** If dental procedure authorization is required to determine	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
					medical necessity for facility and anesthesiologist charges. If approved IH will pay for facility and anesthesiologist charges only. The dental surgeon's charges are the responsibility of the member or other insurance.				
Pain Management	See specific benefit based on where services were rendered.								
Artificial Insemination *Advanced Reproductive Treatment is not covered; this includes Gift, Zift, Etc.*	Member liability based on services rendered.	N/A	Member liability based on services rendered.	Member liability based on services rendered.	**Y** Rx N Artificial Insemination Treatment	N/A	Member liability based on services rendered. **Rx** MUST be obtained from a participating pharmacy.	N/A	N Artificial Insemination Treatment
Assistant Surgeon									
Inpatient	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Autism Mandate									
Assessment for Autism **(Diagnostic test to**	N/A	N/A	N/A	Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
diagnose Autism)							apply.		
Applied Behavioral Analysis (ABA) (Applied Behavioral Analysis (ABA): is an intensive behavioral treatment program that attempts to improve the cognitive and social functioning of children, primarily young children, with autism.) ABA Assessment for Autism	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A
ABA Treatment	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A
Assistant Communication Devices (ACD) Assistive Communication Devices are communication devices and/or software prescribed or ordered for an individual diagnosed with autism spectrum disorder by a licensed physician or licensed psychologist. Note: Laptop computers, personal digital assistants, and iPads or other tablet devices are NOT considered dedicated ACD's and, there, are not covered under this	Not Covered	Not Covered	Not Covered	Not Covered	N/A	N/A	Not Covered	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
mandate.									
Autologous Blood	Subject to deductible then covered in full	Subject to deductible then 30% coinsurance	Subject to deductible then 30% coinsurance	Subject to deductible then 30% coinsurance	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Cardiac Rehabilitation	Covered in full following cardiac surgery, CHF or a myocardial infarction, for up to 36 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	N/A	Subject to deductible and 30% coinsurance following cardiac surgery, CHF or a myocardial infarction for up to 36 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	$20 copayment following cardiac surgery, CHF or a myocardial infarction, for up to 36 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit following cardiac surgery, CHF or a myocardial infarction for up to 36 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	N/A	N
Chemotherapy Treatment (Cancer)	Subject to deductible then covered in full	Subject to deductible then $20 copayment	Subject to deductible and 30% coinsurance	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible then $10/20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Chiropractic Care ***Maintenance Care not covered***	N/A	N/A	N/A	Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A
Clinical Trials	Only Routine Patient Costs of Standard Care covered based on where services rendered				**Y**	N/A	Not Covered	N/A	N/A
Contraceptives administered in the provider's office:	N/A	N/A	N/A	**Devices** dispensed in the office covered in full as a	N	N/A	Subject to deductible and coinsurance up to eligible expenses and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Effective 07/01/2014: The specialty pharmacy dispensing program for these devices (Mirena & Nexplanon) is no longer mandatory.				medical benefit. For insertion, removal or fitting of device, covered in full. Any covered contraceptive device should be purchased and billed by the ordering provider and submitted to IH for reimbursement. **Injections** (Depo Provera) administered in the office covered in full. **If an office visit is required for the management of a new or ongoing condition and an injection is given in conjunction with that visit, then subjectable to deductible then office visit member liability will apply.**			additional payments may apply.		
Contraceptives self-administered/used by the member. • **Cervical Cap** • **Diaphragm** • **NuvaRing®** • **OrthoEvra®**	N/A	N/A	N/A	Covered in full. Prescription coverage is **NOT** required and claims will process in RX Claim.	**Y** See Formulary	N/A	Must use a Participating Pharmacy. See IH Pharmacy Grid for coverage detail.	N/A	**Y** See Formulary

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
• **Oral Contraceptives** • **Female condoms** • **Spermacide**				• Generic drugs/supplies with a physician's prescription • Brand-name drugs/supplies without a generic equivalent with a physician's prescription • OTC drugs/supplies with a physician's prescription. • **Exception:** Emergency contraceptives **DO NOT** require a physician's prescription **EXCEPTION:** **Tier 3 brand name drugs/supplies with generic available will be subject to Member Liability under Rx coverage. If no Rx coverage, Tier 3 brand name drugs/supplies with generic available will be NOT covered.**					

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Cosmetic Surgery	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Member liability based on services rendered.**	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Member liability based on services rendered.**	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Member liability based on services rendered.**	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Member liability based on services rendered.**	**Y**	N/A	Not covered. Covered when medically necessary for reconstructive surgery when incidental to or when it follows surgery resulting from trauma, infection or other diseases of the involved body part. **Member liability based on services rendered.**	N/A	**Y**
Dental (Preventive and Routine)	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Accidental Dental	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	Medically necessary dental services when necessitated by accidental injury to sound natural teeth are covered within 12 months of the accident. **Member liability based on services rendered.**	**Y** Required after the emergency exam and x-rays.	N/A	Covered as an **in-network** benefit.	N/A	N/A
Congenital Disease and Anomaly	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	Member liability based on services rendered when deemed medically necessary.	**Y**	N/A	Member liability based on services rendered when deemed medically necessary.	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Diabetic									
Diabetic Equipment (e.g. Blood Glucose Monitor)	N/A	N/A	N/A	Deductible, then covered in full	**Y** See Provider Auth List	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Equipment Insulin Pump	N/A	N/A	N/A	Deductible, then covered in full	**Y** See Provider Auth List	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Supplies	N/A	N/A	N/A	Deductible, then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Teaching	Covered in full	Covered in full	Covered in full	Covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Diabetic Shoes	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Insulin, Oral Agents	See Prescription Benefit	See Prescription Benefit	See Prescription Benefit	See Prescription Benefit	N	N/A	Must use a Participating Pharmacy.	N/A	**Y** See Formulary
Diagnostic Testing (e.g. EKG, Stress Tests, not Lab or X-rays)	Subject to deductible then covered in full **Member liability does not apply if service is listed on Preventive Services Grid.**	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 30% coinsurance **Member liability does not apply if service is listed on Preventive Services Grid.**	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Dialysis									

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Outpatient Facility	Subject to deductible then covered in full	Subject to deductible then $20 copayment	Subject to deductible and 30% coinsurance	Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient Physician	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Durable Medical Equipment (DME)	N/A	N/A	N/A	Subject to deductible then 20% coinsurance **Member liability does not apply if service is listed on Preventive Services Grid.**	**Y** See Provider Auth Grid	N/A	Subject to a deductible and coinsurance up to eligible expenses	N/A	**Y**
ECT	**See Mental Health.**	**See Mental Health.**	**See Mental Health.**	**See Mental Health.**	N/A	N/A	**See Mental Health.**	N/A	N/A
Emergency Care									
Emergency Room Facility - also see Urgent Care	Effective 1/1/16 Subject to deductible then $250 copayment at any hospital worldwide. Prior to 1/1/16 deductible then $125 copay Copayment is waived if admitted.	Effective 1/1/16 Subject to deductible then $250 copayment at any hospital worldwide. Prior to 1/1/16 deductible then $125 copay Copayment is waived if admitted.	Effective 1/1/16 Subject to deductible then $250 copayment at any hospital worldwide. Prior to 1/1/16 deductible then $125 copay Copayment is waived if admitted.	N/A	N	N/A	Covered as an **in-network** benefit.	N/A	N/A
ER Physician	Subject to deductible then covered in full	Subject to deductible then covered in full	Subject to deductible then covered in full	Subject to deductible then covered in full	N	N/A	Covered as **in-network** benefit	N/A	N/A
ER Follow Up Visit	Subject to deductible then	Subject to deductible then	Subject to deductible then	N/A	N	N/A	Covered as **in-network** benefit	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	office visit or emergency room copayment may apply	office visit or emergency room copayment may apply	office visit or emergency room copayment may apply						
Observation Beds – Facility	Subject to deductible then $250 copayment at any hospital worldwide. If ER copayment & observation facility copayment are billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	Subject to deductible then $250 copayment at any hospital worldwide. If ER copayment & observation facility copayment are billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	Subject to deductible then $250 copayment at any hospital worldwide. . If ER copayment & observation facility copayment are billed, member is only responsible for one copayment, including if care continued past midnight and is billed as two days.	N/A	N	N/A	Covered as **in-network** benefit	N/A	N/A
Observation Beds - Physician	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Covered as **in-network** benefit	N/A	N/A
Experimental/ Investigational	Only Routine Patient Costs of Standard Care covered based on where services rendered				Y	Y	Refer to SPD	N/A	Y
Hearing									
Hearing Tests	Subject to deductible then covered in full	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $20 copayment	Subject to deductible and 30% coinsurance	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Evaluation and Fitting for Hearing Aids	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Hearing Aids	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
.	***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**	***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**			***Exception:*** *Cochlear Implant & Bone Anchored Hearing Aid BAHA is covered if medically necessary* **For member liability see Outpatient Surgical benefits.**		
Home Health Care/ Aide **1 Home Health Aide visit = up to 4 continuous hours.**	**Erie & Niagara County:** Subject to deductible then covered in full for up to 90 visits per plan year. **All visit limits cross accumulate towards each benefit maximum.**	N/A	**Erie & Niagara County only:** Subject to deductible and 30% coinsurance with 40 visits per plan year. **All other WNY counties**: Subject to deductible then $20 copayment with 45 visits per plan year. **All visit limits cross accumulate towards each benefit maximum.**	Subject to deductible then $20 copayment with 40 visits per plan year. **All visit limits cross accumulate towards each benefit maximum.**	**Y** Required before the first visit.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 40 visits per plan year. **All visit limits cross accumulate towards each benefit maximum.**	N/A	**Y** Required before the first visit.
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Home Infusion Therapy (for Enteral and Parenteral, see Nutritional Supplies)									
Nursing Services/Visits	**Erie & Niagara County:** Subject to deductible then covered in full with no visit	**N/A**	**Erie & Niagara County:** Subject to deductible and 30% coinsurance with no visit	Subject to deductible then covered in full with no visit limitation.	**Y** See MRM Home Infusion Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no visit	N/A	**Y** Required before the first visit.

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	limitation.		limitation. **All other WNY counties**: Covered in full with no visit limitation.				limitation.		
Medication	**Erie & Niagara County:** Subject to deductible then covered in full.	**N/A**	**Erie & Niagara County**: Subject to deductible and 30% coinsurance. **All other WNY counties:** Subject to deductible then covered in full.	Subject to deductible then covered in full.	**Y** See Rx Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Required before the first visit.
Other Services (e.g. supplies and per diem items)	**Erie & Niagara County:** Subject to deductible then covered in full.	**N/A**	**Erie & Niagara County**: Subject to deductible and 30% coinsurance. **All other WNY counties:** Subject to deductible then covered in full.	Subject to deductible then covered in full.	**Y** See MRM Home Infusion Policy	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Required before the first visit.
Home Visit (other than Home Health Care or Home Infusion Therapy)	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Hospice (includes Bereavement Counseling)									
Advance Care Planning	N/A	N/A	N/A	Subject to deductible the covered in full for up to 6 visits per plan year.	N	N/A	Not covered	N/A	N
Inpatient	N/A	N/A	N/A	Subject to	N	N/A	Subject to deductible	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				deductible then covered in full with no day limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs.			and coinsurance up to eligible expenses and additional payments may apply per admission with no day limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. **Rapid readmission does NOT apply.**		
Outpatient (Home)	N/A	N/A	N/A	Subject to deductible then covered in full with no visit limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may per visit with no visit limitations. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs. In addition, family members are entitled to bereavement counseling.	N/A	N
Hospital - Inpatient (Room and Board)	Subject to deductible then covered in full.	Subject deductible then a to $250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year. **If admitted through ER,**	Subject to deductible and 30% coinsurance. **If admitted through ER,** subject to deductible then covered in full. **Rapid readmission**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission unless admitted through the emergency room. **Rapid readmission does NOT apply.**	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
		subject to deductible then covered in full.	**does NOT apply.**				**If admitted through ER,** subject to deductible then covered in full.		
Hospital - Inpatient - Medical Rehab Facility	Subject to deductible then covered in full for up to 45 days per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then a $250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year for up to 45 days per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible and 30% coinsurance for up to 45 days per plan year. **Rapid readmission does NOT apply.** In-network plus out-of-network services combined equal the total benefit.	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission for up to 45 days per plan year. In-network plus out-of-network services combined equal the total benefit. **Rapid readmission does NOT apply.**	N/A	**Y**
Immunizations									
Adult Immunizations (19 and over) **Shingles vaccine ages 60 and over*	N/A	N/A	N/A	Covered in full **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit, then subject to deductible then $10/$20 office visit member liability will apply.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Child Immunizations (0-18 years) *ACIP = Advisory Committee of Immunization Practices*	N/A	N/A	N/A	Covered in full up to the age of 19 according to ACIP guidelines if billed alone or with a well visit. **If an office visit is required for the management of a new or ongoing condition and an immunization is given in conjunction with that visit, then subject to deductible then $20 office visit member liability will apply.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Infertility *Advanced Reproductive Treatment is not covered.*	Member liability based on services rendered.	N/A	Member liability based on services rendered.	Member liability based on services rendered.	**Y** Rx N Infertility Treatment	N/A	Member liability based on services rendered. **Rx** MUST be obtained from a participating pharmacy.	N/A	**Y** Rx N Infertility Treatment
Injections – Office-Based *(not self administered)*	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment	**Y** Refer to Injectable Formulary for pre-auth requirements.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Laboratory & Pathology	Subject to deductible then covered in full.	Subject to deductible then covered in full.	Subject to deductible and 30% coinsurance.	**If member goes to an Independent Lab:** Subject to	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				deductible and 30% coinsurance **If collected in a doctor's office and is sent out or processed in doctor's office:** subject to deductible then **c**overed in full.			apply.		
Mammograms									
Technical Services	Covered in full.	Covered in full.	Covered in full.	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Professional Services	Covered in full.	Covered in full.	Covered in full.	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mastectomy Post-Mastectomy									
Breast Prosthesis	N/A	N/A	N/A	Subject to deductible then covered in full with no limitations. *(Women's Cancer Rights Act)*	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no limitations. *(Women's Cancer Rights Act)*	N/A	N
Post Mastectomy Supplies (Bras)	N/A	N/A	N/A	Subject to deductible then covered in full with no limitations. *(Women's Cancer Rights Act)*	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply with no limitations.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							(Women's Cancer Rights Act)		
Reconstructive Surgery	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	**See Hospital and Outpatient Surgical Procedures**	N/A	N/A	**See Hospital and Outpatient Surgical Procedures**	N/A	N/A
Maternity Care									
Breast Feeding/Lactation Support *See home care benefit for nursing visits.*	Covered in full	Covered in full	Covered in full	Covered in full	N/A	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Prenatal & Postnatal Visits ***Note:** If a visit is unrelated to pregnancy member liability may apply based on services rendered.*	N/A	N/A	N/A	Covered in full after initial diagnosis.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Sonogram(s)	Subject to deductible then covered in full	N/A	Subject to deductible and 30% coinsurance	Subject to deductible then $20 copayment		N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Delivery- Facility	Subject to deductible the covered in full.	N/A	Subject to deductible and 30% coinsurance **Rapid readmission DOES NOT apply.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission DOES NOT apply.**	N/A	N
Delivery- Physician	N/A	N/A	N/A	Subject to deductible the covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Newborn-Facility	Subject to	Subject to	Subject to	N/A	N	N/A	Subject to deductible	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	deductible the covered in full.	deductible then covered in full	deductible and 30% coinsurance.				and coinsurance up to eligible expenses and additional payments may apply per admission. **Rapid readmission DOES NOT apply.**		
Newborn-Physician	N/A	N/A	N/A	Subject to deductible the covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Home Birth	N/A	N/A	N/A	Subject to deductible the covered in full.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Home Visit (Resulting from early discharge)	Subject to deductible the covered in full.	N/A	Subject to deductible and 30% coinsurance.	Subject to deductible the covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Medical Supplies	Subject to deductible the covered in full.	Subject to deductible the covered in full.	Subject to deductible and 30% coinsurance.	Subject to deductible the covered in full.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y**
Medical Expendable Supplies	**Erie & Niagara County only:** Subject to deductible then covered in full only when in conjunction with authorized skilled nursing services in the home.	N/A	**Erie & Niagara County only:** Subject to deductible and 30% coinsurance only when in conjunction with authorized skilled nursing services in the home. **All other WNY counties**: Subject to deductible then covered in full	Subject to deductible then covered in full only when in conjunction with authorized skilled nursing services in the home.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply only when in conjunction with authorized skilled nursing services in the home.	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
			only when in conjunction with authorized skilled nursing services in the home						
Mental Health									
Electroconvulsive (ECT) Facility Outpatient (e.g. Shock Therapy) **Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit**.	N/A	Subject to deductible then a $75 copayment	Subject to deductible and 30% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Electroconvulsive (ECT) Physician Outpatient (e.g. Shock Therapy) **Note: ECT therapy during inpatient admission, refer to Mental Health Inpatient Facility section for benefit**	N/A	N/A	N/A	Subject to deductible then covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mental Health Inpatient Facility	Subject to deductible then covered in full.	Subject to deductible then a $ 250 copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year.	Subject to deductible and 30% coinsurance. **Rapid readmission DOES NOT apply.**	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Rapid readmission does NOT apply.**	N/A	**Y**
Mental Health Inpatient Physician	N/A	N/A	N/A	Subject to deductible then covered in full.	**Y** Psychologist, CSW	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
					N Psychiatrist, Nurse Practitioner with a secondary specialty of psychiatry.		apply.		
Mental Health Outpatient	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	Subject to deductible and 30% coinsurance	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Mental Health Partial Hospitalization Care that is provided in lieu of inpatient mental health hospitalization at an approved facility.	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	Subject to deductible and 30% coinsurance	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for each partial hospitalization day.	N/A	**Y**
Pharmacological (chemotherapy) Management A brief interaction between a psychiatrist and a member for the primary purpose of reviewing medications and issuing a prescription with minimal psychotherapy	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	Subject to deductible and 30% coinsurance	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible $10 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Residential Treatment	N/A	Subject to $ 250	Subject to	N/A	**Y**	N/A	Subject to deductible	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Residential Treatment Intensive Residential Rehabilitation Services are Residential Services requiring 24/7 treatment in a structured environment. Note: Community Residential Services and Supportive Living Services are NOT covered.		copayment. Up to 2 copayments ($500 max) will be applied for family coverage per plan year.	deductible and 30% coinsurance. **Rapid readmission DOES NOT apply.**				and coinsurance up to eligible expenses and additional payments may apply.		
MRI & MRA	**See Radiology Services (Advanced)**								
Nutritional Counseling	Covered in full	Covered in full	Covered in full	Covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Nutritional Supplies									
Enteral & Parenteral Pumps	**See DME**	**See DME**	**See DME**	**See DME**	N/A	N/A	**See DME**	N/A	N/A
Parenteral Nutritional Supplies **<u>Parenteral Nutrition</u>** A feeding method in which nutrients go directly into the bloodstream through a catheter/IV placed into a vein, nutrition taken intravenously bypassed the digestive tract. You may also see terms TPN (total parenteral nutrition) or HA (hyperalimentation) used.	**Erie & Niagara County:** If provided in conjunction with Home Infusion visit subject to deductible then covered in full.	N/A	**Erie & Niagara County only:** If provided in conjunction with Home Infusion visit subject to deductible and 30% coinsurance. **All other WNY counties:** If provided in conjunction with Home Infusion visit covered in full.	**If provided in conjunction with Home Infusion visit**, Subject to deductible then covered in full.	**Y** Home Infusion See MRM Parenteral / Enteral Policy	N/A	**If provided in conjunction with authorized Home Infusion visit**, subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Enteral Formula & Supplies **<u>Enteral Nutrition</u>** Giving supplemental nutrition through a special **feeding tube*** that enters directly into the stomach or small intestine. ***Feeding Tube** – placed directly into the stomach through an opening in the abdominal wall or inserted through the nose, the G-tube, J-tube, GJ-tube, NG-tube and/or extension tube through which formula, fluids and/or medication are given.	**Erie & Niagara County:** If provided in conjunction with Home Infusion visit, then see the Home Infusion benefit. **If provided as a prescription**, Rx member liability may apply.	N/A	**Erie & Niagara County only:** If provided in conjunction with Home Infusion visit, then see the Home Infusion benefit. **All other WNY counties:** If provided in conjunction with Home Infusion visit, then see the Home Infusion benefit. **If provided as a prescription,** Rx member liability may apply.	If provided in conjunction with Home Infusion visit, then see the Home Infusion benefit. **If provided as a prescription**, Rx member liability may apply.	**Y** Home Infusion See MRM Parenteral / Enteral Policy **Y** Rx	N/A	**If provided in conjunction with authorized Home Infusion visit**, subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **If provided as a prescription,** <u>not covered</u> at an out-of-network pharmacy.	N/A	**Y** Rx (if written by a non-par provider) N Home Infusion
PKU Food Supplements	N/A	N/A	N/A	Covered as a pharmacy benefit. **Rx member liability may apply.**	N	N/A	Covered as a pharmacy benefit. **Rx member liability may apply.**	N/A	N
Occupational Therapy	**See Therapies**								
Office Visits	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment **Member liability does not apply if service is listed on Preventive Services**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				Grid.					
Orthotics Custom molded shoe inserts are not covered.	N/A	N/A	N/A	Subject to deductible then 20% coinsurance	**Y**	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Ostomy Supplies	N/A	N/A	N/A	Subject to deductible then 20% coinsurance	N	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Outpatient Surgical Procedures									
Facility *Gastric Bypass is covered when medically necessary.*	Subject to deductible then covered in full **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible, then $75 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 30% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	N/A	N **Y** If dental procedure authorization is required to determine medical necessity for facility and anesthesiologist charges. If approved IH will pay for facility and anesthesiologist charges only. The dental surgeon's charges are the responsibility of the member or other insurance.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** Service Classes 006, 010
Physician - Facility Based	N/A	N/A	N/A	Subject to deductible then covered in full.	**Y** See Provider Auth Grid	N/A	Subject to deductible and coinsurance up to eligible expenses and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							additional payments may apply.		
Physician - Office Based	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	**Y** See Provider Auth Grid	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	**Y** See Provider Auth Grid
Eye Surgery Benefit *Appears not set up in Health rules- falling to amb surg .*	Subject to deductible then Covered in full	Subject to deductible then $75 copayment	Subject to deductible then $75 copayment	Subject to deductible and $20 copayment	N	N	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Other outpatient services not listed *(e.g. IV therapy, infusion, blood transfusions, etc.)*	Subject to deductible the covered in full	Subject to deductible then $20 copayment	Subject to deductible and 30% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Pap Smear & HPV Testing	N/A	**Visit:** N/A **Lab test:** Covered in full	**Visit:** N/A **Lab test:** Covered in full	**Visit:** See Preventive Service List Grid or Office Visit benefit. **Lab test:** Covered in full	N	N/A	**Visit:** Subject to deductible and coinsurance up to eligible expenses and additional payments may apply. **Lab Test:** Subject to deductible and coinsurance up to	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							eligible expenses and additional payments may apply.		
Physical Therapy	**See Therapies**								
Physician Visit (Inpatient)	N/A	N/A	N/A	**Visit:** Subject to deductible then covered in full. **Surgery:** Subject to deductible then covered in full.	N for visit **Y** for certain procedures	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatry									
Facility – Outpatient	Subject to deductible then covered In full	Subject to deductible then $75 copayment	Subject to deductible and 30% coinsurance.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Facility Outpatient Based	N/A	N/A	N/A	Subject to deductible then covered In full	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Office Based Surgical Procedures	N/A	N/A	N/A	Subject to deductible and $20 copayment See Reimbursement Policy.	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Podiatrist – Office Visit (E&M)	N/A	N/A	N/A	Subject to deductible and $20 copayment See Reimbursement Policy.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Prescription Drugs (Rx)	N/A	N/A	N/A	Covered through PBD. Subject to deductible $5/$25/$50 See IH Pharmacy Grid for coverage detail.	**Y** See Formulary	N/A	MUST be obtained from a participating pharmacy even when written by a non-participating provider.	N/A	**Y** See Formulary

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Prosthetics and Appliances (P&A) External only	N/A	N/A	N/A	Subject to deductible then 20% coinsurance	**Y**	N/A	Subject to deductible and 50% coinsurance up to eligible expenses and additional payments may apply.	N/A	N/A
Pulmonary Rehab	Subject to deductible then Covered in full for up to 24 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 24 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible and 30% coinsurance for up to 24 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 24 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	N	N/A	Subject to deductible and coinsurance for up to 24 visits per plan year. In-network plus out-of-network services combined equal the total benefit.	N/A	**Y**
Radiation Therapy									
Technical Services	Subject to deductible then covered in full	Subject to deductible then a $20 copayment	Subject to deductible and 30% coinsurance.	Subject to deductible then a $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Professional Services	Subject to deductible then covered in full	Subject to deductible then covered in full	Subject to deductible and 30% coinsurance.	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Radiology (X-rays)									
Routine X-rays Technical Services	Subject to deductible then covered in full	Subject to deductible then a $20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 30% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible then **0-18:** $20 copayment **19 and older:** $10/$20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Routine X-rays Professional Services	Subject to deductible then covered in full	Subject to deductible then covered in full	Subject to deductible and 30% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Advanced Radiology Technical Services Advanced Radiology Services includes: MRI, MRA, CT Scan, PET Scan and Myocardial Nuclear Perfusion Imaging.	Subject to deductible then covered in full	Subject to deductible then a $20 copayment	Subject to deductible and 30% coinsurance.	Subject to deductible then a $20 copayment	**Y** Outpatient, non-emergent by **ordering provider** through NIA.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Advanced Radiology Professional Services	Subject to deductible then covered in full	Subject to deductible then covered in full	Subject to deductible and 30% coinsurance.	Subject to deductible then covered in full	**Y** Outpatient, non-emergent by **ordering provider** through NIA.	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Reversal of Elective Sterilization	Not covered	Not covered	Not covered	Not covered	N/A	N/A	Not covered	N/A	N/A
Routine Physicals (19 & older)	N/A	N/A	N/A	Covered in full This applies to services rendered by a physician in an office setting **excluding:** procedures, injections, diagnostic services, laboratory and x-ray services, and any other service not billed as an evaluation and management code	N	N/A	Not covered	N/A	N/A

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				(E&M code). **See specific benefit for any additional services rendered.**					
Scopes	**e.g. colonoscopy, flexible sigmoidoscopy, esophagogastroduodenoscopy (EGD)**								
Facility – Outpatient	Subject to deductible then covered in full. **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible then $75 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	Subject to deductible and 30% coinsurance. **Member liability does not apply if service is listed on Preventive Services Grid.**	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Facility Outpatient Based	N/A	N/A	N/A	Subject to deductible the covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Office Based Scope Procedures	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible then $10/$20 copayment **Member liability does not apply if service is listed on Preventive Services Grid.**	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Skilled Nursing Facility (sub-acute)									
Facility	Subject to deductible then covered in full for up to 90 days per plan year.	Subject to deductible then a $250 copayment. Up to 2 copayments	Subject to deductible and 30% coinsurance for up to 45 days per plan year	N/A	**Y**	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up to 45 days	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	Note: Custodial care is not covered. **In-network plus out-of-network services combined equal the total benefit.**	($500 max) will be applied for family coverage per plan year for up to 45 days which counts toward the 90 days global limit per plan year benefit. **Note:** Custodial care is not covered. **In-network plus out-of-network services combined equal the total benefit.**	which counts toward the 90 days global limit per plan year benefit. **Note:** Custodial care is not covered. **In-network plus out-of-network services combined equal the total benefit.** **Rapid readmission does NOT apply.**				per plan year which counts toward the 90 days global limit per plan year benefit. **Note:** Custodial care is not covered. **In-network plus out-of-network services combined equals the total benefit.** **Rapid readmission does NOT apply.**		
Physician/Ancillary Visits	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Sleep Studies	Subject to deductible then covered in full	Subject to deductible then a$20 copayment	Subject to deductible and 30% coinsurance	Subject to deductible then a$20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Smoking Cessation	Covered in full for telephonic support and NRT products through the NYS Quitline. See below for Chantix and Zyban coverage. The telephone number for the NYS Quitline is 1-866-NY-QUITS (1-866-697-8487). Telephonic Support with NRT: After an assessment with a Quitline Specialist, eligible members are sent a free starter supply of NRT from the NYS Smokers Quitline. Roswell's Inhale Life phone coach calls member approximately two weeks later. If the member and the coach determine that the NRT is working and the member enrolls in Independent Health's telephonic support program, an additional two weeks of NRT is mailed directly to the member's home. The member will receive a call from Roswell's Inhale Life phone coach. Member is eligible for up to a total of 8 weeks of NRT products. This program is provided at no additional cost for eligible members. NOTE: The member must engage in the telephonic support program in order to receive NRT coverage.						Not Covered	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	Chantix and Zyban are covered if the member has pharmacy coverage. If the member is not successful and wants to attempt to quit again, they need to contact the NYS Quit line. Classes are available in lieu of coaching calls. For information on available classes, members should call the NYS Smoker's Quitline. **Roswell will bill Independent Health for coaching calls and additional NRT product dispensed outside of the NYS Quit line and these claims will process as a medical claim.**								
Speech Therapy	**See Therapies**								
Termination of Pregnancy									
Facility	N/A	Subject to deductible then $75 copayment	Subject to deductible then $75 copayment	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Facility Based	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician - Office Based	N/A	N/A	N/A	**0-18:** Subject to deductible then $20 copayment **19 and over:** Subject to deductible then $10/20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Therapies-Outpatient **(Physical Therapy, Occupational Therapy**	**THERAPIES (see below)**								
Occupational Therapy	Subject to deductible then covered in full for up to 20 visits combined with PT and ST per	Subject to deductible then $20 copayment for up to 20 visits combined with PT and ST per	Subject to deductible and 30% coinsurance for up to 20 visits combined with PT and ST per plan	Subject to deductible then $20 copayment for up to 20 visits combined with PT and ST per plan	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit for up to 20 visits per plan year	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
	plan year. In-network plus out-of-network services combined equals the total benefit.	plan year. In-network plus out-of-network services combined equal the total benefit.	year. In-network plus out-of-network services combined equal the total benefit.	year. In-network plus out-of-network services combined equal the total benefit.			combined with PT and ST, including evaluation(s). In-network plus out-of-network services combined equals the total benefit.		
Physical Therapy	Subject to deductible then covered in full for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible and 30% coinsurance for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 20 visits combined with OT and ST per plan year. In-network plus out-of-network services combined equal the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply for up 20 visits per plan year combined with OT and ST, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	N/A	N
Speech Therapy	Subject to deductible then covered in full for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	Subject to deductible and 30% coinsurance for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	Subject to deductible then $20 copayment for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply per visit for up to 20 visits per plan year combined with OT and PT, including evaluation(s). In-network plus out-of-network services combined equal the total benefit.	N	N/A
TMJ Treatment	Coverage based on services rendered	Coverage based on services rendered	Coverage based on services rendered	Coverage based on services rendered	N/A	**Y**	Coverage based on services rendered	N/A	**Y**

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
Transplants									
Donor (donates the organ)	N/A	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. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	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. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	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. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	**Y** (If IH member)	N/A	Claims need to be submitted to the donor's insurance company. An EOB from the other insurance then needs to be submitted to IH. IH will reimburse for the donation charges under the recipient's IH ID # if the other insurance carrier denies the claim or if there is a balance remaining once the other insurance has paid. IH will coordinate benefits. Costs and/or services related to searches and/or screenings for donors of organs to be transplanted are not covered. **If authorized, member liability based on services rendered.**	N/A	**Y** (If IH member)
Recipient (receives the organ)	N/A	Recipient must be a member of IH.	Recipient must be a member of IH.	Recipient must be a member of IH.	**Y** (Except for Corneal	N/A	Recipient must be a member of IH.	N/A	**Y** (Except for Corneal

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
		If authorized, member liability based on services rendered.	**If authorized, member liability based on services rendered.**	**If authorized, member liability based on services rendered.**	Transplants)		**If authorized, member liability based on services rendered.**		Transplant)
Tubal Ligation									
Facility	Covered in full.	N/A	Covered in full.	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician – Facility Based	N/A	N/A	N/A	Covered in full.	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Urgent Care									
In-Area	N/A	N/A	N/A	If member receives urgent care in a participating physician's office: **0-18:** Subject to deductible then $20 copayment **19 and older:** Subject to deductible then $10/$20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Participating After Hours Care	N/A	N/A	N/A	Subject to deductible then $35 copayment	N	N/A	Not Applicable. See urgent care out-of-area.	N/A	N/A
Out-of- Area	N/A	N/A	N/A	If the member calls 24-Hour Medical Help Line prior to services being rendered, the member is responsible for in-	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
				network copayments. The deductible then $20 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). Reimbursement will be either the lesser of billed charges or at the 80th percentile of the usual, customary and reasonable rate (UCR) of the region where the member received care, minus the applicable copayment(s). Members are responsible for the difference between Independent Health's reimbursement and the provider(s) billed charges, unless a participating First Health provider.					
Vasectomy									
Facility	N/A	N/A	Subject to deductible then $75 copayment	N/A	N	N/A	Subject to deductible and coinsurance up to eligible expenses and	N/A	N

	First Choice Tier 1	Specialty Services	Non First Choice Tier 2	Par Physician and Ancillary Services (IHC Network)	Provider Pre-auth	Member Pre-Cert	Out of Network	Provider Pre-auth	Member Pre-Cert
							additional payments may apply.		
Physician - Facility Based	N/A	N/A	N/A	Subject to deductible then covered in full	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Physician - Office Based	N/A	N/A	N/A	Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Vision	**Vision (EyeMed Insight Network 1.877.842.3348)**			**Plan # 9863747**					
Medical	N/A	N/A	N/A	Subject to deductible then $20 copayment	N	N/A	Subject to deductible and coinsurance up to eligible expenses and additional payments may apply.	N/A	N
Optical Dispensing Routine/ Refractive Post Cataract Lenses	N/A	N/A	N/A	Covered through EyeMed **Routine/Refractive Exam**- $0 copayment once every 12 months	N/A	N/A	Not covered	N/A	N/A
Well Baby/Child Care *AAP = American Academy of Pediatrics*	N/A	N/A	N/A	Covered in full up to age 19 according to AAP guidelines.	N	N/A	Not Covered	N/A	N/A

Plan Name/Year 7.1.15 -6.30.16 - 24522- First Choice HDHP

_____ _____

Authorized Person's Name Title

_____ _____

Authorized Person's Signature Date