Benefit Summary

Plan Name:	iDirect Gold Copay Option 2		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$1,250 / $2,500	$5,000 / $10,000	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	50%	
Out-of-Pocket Maximum	$6,750 / $13,500	$10,000 / $20,000	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
Annual Maximum	Not Applicable	Not Applicable	
Lifetime Maximum	Not Applicable	Not Applicable	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy Sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal visits Post-Partum visits Prostate test (Prostate Specific Antigen "PSA") Well-Child visit Well-Woman visit	$0	Deductible then 50% coinsurance	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	$20 copay / visit	Deductible then 50% coinsurance	PCP Required. In-Network Deductible does not apply
Specialist Office Visit	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Allergy Testing & Treatment	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures (in physician's office)	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Telemedicine - General Medical Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Behavioral Health Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Dermatology	Deductible then $50 copay / consultation	Not Covered	Administered by Teladoc

Benefit Summary

Plan Name:	iDirect Gold Copay Option 2		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Emergency & Urgent Care Services			
Emergency Room	Deductible then $150 copay / visit	Deductible then $150 copay / visit	Copay waived if admitted
Ambulance	Deductible then $150 copay / trip	Deductible then $150 copay / trip	Must be deemed medically necessary
Urgent Care Center	$75 copay / visit	$75 copay / visit	In-Network Deductible does not apply
Hospital and Other Facility Services			
Inpatient Hospital	Deductible then $750 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 50% coinsurance	
Inpatient Hospice	Deductible then $0 copay / admission	Deductible then 50% coinsurance	Up to 210 days per plan year
Outpatient Surgical Procedures (Hospital Facility)	Deductible then $125 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	Deductible then $100 copay / visit	Deductible then 50% coinsurance	
Outpatient Surgical Procedures: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 50% coinsurance	
Skilled Nursing Facility	Deductible then $750 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	Deductible then $20 copay / visit	Deductible then 50% coinsurance	
EKG	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine Radiology	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Advanced Radiology	Deductible then $85 copay / visit	Deductible then 50% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$0 copay / visit	Deductible then 50% coinsurance	In-Network Deductible does not apply No charge after the initial diagnosis
Inpatient Maternity	Delivery: Deductible then $750 copay / admission Physician: Deductible then $0 copay / procedure	Deductible then 50% coinsurance	Semi-private room, per admission

Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay Option 2		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Mental Health & Substance Abuse			
Inpatient Mental Health	Deductible then $750 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Outpatient Mental Health	$20 copay / visit	Deductible then 50% coinsurance	In-Network Deductible does not apply
Inpatient Substance Abuse - Rehab	Deductible then $750 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Inpatient Substance Abuse - Detox	Deductible then $750 copay / admission	Deductible then 50% coinsurance	Semi-private room, per admission
Outpatient Substance Abuse	$20 copay / visit	Deductible then 50% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$0 copay	Deductible then 50% coinsurance	
Insulin and Other Oral Agents	$20 copay	Deductible then 50% coinsurance	Maximum of $100 per 30 day supply for insulin only
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 copay	Deductible then 50% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then $50 copay / visit	Deductible then 50% coinsurance	60 visits per condition, per plan year combined therapies
Cardiac Rehabilitation	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Pulmonary Rehabilitation	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Additional Services			
Durable Medical Equipment	Deductible then 50% coinsurance	Deductible then 50% coinsurance	
Prosthetics and Appliances	Deductible then 50% coinsurance	Deductible then 50% coinsurance	
Chemotherapy Visits	$20/Deductible then $50 copay / visit	Deductible then 50% coinsurance	See Medications Administered in an Office or Outpatient Hospital Setting for additional member liability
Medications Administered in an Office or Outpatient Hospital Setting	10% coinsurance / Deductible then 10% coinsurance	Deductible then 50% coinsurance	Excludes Allergy Injections
Home Health Care	Deductible then $50 copay / visit	Deductible then 50% coinsurance	Up to 40 visits per plan year
RedShirt Rewards	Earn up to $30 in rewards for covered members ages 18 and up per plan year for completing health related actions.	Not Covered	
Unique Benefits	Health Extras: $250 allowance per Plan Year or Nutrition Reimbursement: Up to $500 per individual/$1,000 per family	Not Covered	After your effective date you must choose either Health Extras or Nutrition Reimbursement

Benefit Summary

Plan Name:	iDirect Gold Copay Option 2		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Prescription Drug Coverage			
Prescription Plan	$10/$40/$100	Not Covered	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary III. Cost-share, if applicable, does not apply to certain prescription drugs. Visit our website to review our formulary.
Maintenance Medications	2.5 copays for a 3 month supply, Deductible may apply	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
Medicare Part D Creditable Coverage Status	Creditable*	Not Applicable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.
Pediatric Vision Services			
Medical Eye Exam	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine/ Refractive Exam	$20 copay / visit	Not Covered	In-Network Deductible does not apply Once every 12 months.
Standard Plastic Lenses	30% coinsurance	Not Covered	In-Network Deductible does not apply. Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
Frames	30% coinsurance	Not Covered	Once every 12 months
Conventional Contact Lenses	30% coinsurance	Not Covered	Once every 12 months. In lieu of frames/lenses. Materials only.
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Adult Vision Services			
Medical Eye Exam	Deductible then $50 copay / visit	Deductible then 50% coinsurance	
Routine/ Refractive Exam	$40 copay / visit	Not Covered	Once every 12 months
Standard Plastic Lenses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% off most retail frames	Not Covered	
Conventional Contact Lenses	15% off retail price	Not Covered	Materials only
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	

Benefit Summary

Plan Name:	iDirect Gold Copay Option 2		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
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
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 maximum must be met before Independent Health provides reimbursement for covered 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.

Non-Embedded (True Family) - On a single policy, the single deductible/out-of-pocket maximum must be met before Independent Health provides reimbursement for covered services. On a family policy, the entire family deductible/out-of-pocket maximum must be met before Independent Health provides reimbursement for covered services. An individual on a family policy will NOT stop at the single deductible/out-of-pocket maximum.

In-area Non-Participating Providers: Services provided by a non-participating provider in the 8 counties of WNY are Not covered.

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-Authorization: Certain services and benefits are subject to member pre-authorization. Member is responsible for contacting Independent Health for pre-authorization.

Child (if applicable): Cost-share applies if member is under the age of 19

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information, consult your Contract, attached Riders (if any), or Certificate of Coverage.

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

Certain benefits stated in this benefit summary may be pending NYS approval.

*It is the employer's responsibility to determine whether or not coverage is creditable. This information is provided at your convenience and it is recommended that you consult your benefits counsel for confirmation of creditable coverage status.