Independent Health

**Account Name:** NYS Employee Insurance Accounting
**Account #:** 22652
**Sales Representative:** Joel Marinaccio
**Plan Effective Date:** January 1, 2027

# Benefit Summary

| Plan Name: | NYSHIP | |
|---|---|---|
| **Benefits** | **In-Network** | **Additional Information** |
| **General Information** | | |
| Deductible | $0 | |
| Coinsurance | Applies Where Indicated | |
| Out-of-Pocket Maximum | $4,000 / $8,000 | Where the out of pocket max applies it accumulates as embedded.<br>*See Important Notes section for more detail. |
| Annual Maximum | Not Applicable | |
| **Preventive Services** | | |
| Bone mineral density measurements or tests<br>Cholesterol test (lipid panel)<br>Colonoscopy<br>Sigmoidoscopy<br>Contraceptive Drugs, Devices and Counseling<br>Immunizations<br>Mammogram<br>Pap smear<br>Physical exam<br>Prenatal visits<br>Post-Partum visits<br>Prostate test (Prostate Specific Antigen "PSA")<br>Well-Child visit<br>Well-Woman visit | $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<br>Child: $0 copay / visit | |
| Specialist Office Visit | $20 copay / visit | |
| Allergy Testing & Treatment | Adult: $10/20 copay / visit<br>Child: $0/$20 copay / visit | |
| Outpatient Surgical Procedures (in physician's office) | Adult: $10/$20 copay / visit<br>Child: $0/$20 copay / visit | |
| Telemedicine - General Medical Services | $0 copay / consultation | Administered by Teladoc |
| Telemedicine - Behavioral Health Services | $0 copay / consultation | Administered by Teladoc |
| Telemedicine - Dermatology | $0 copay / consultation | Administered by Teladoc |
| **Emergency & Urgent Care Services** | | |
| Emergency Room | $100 copay / visit | Copay waived if admitted |
| Ambulance | $100 copay / trip | Must be deemed medically necessary |
| Urgent Care Center | Adult: $35 copay / visit<br>Child: $0 copay / visit | |


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| **Hospital and Other Facility Services** | | |
| Inpatient Hospital | $0 copay / admission | Semi-private room, per admission |
| Inpatient Hospital: Physician/Surgeon Fees | $0 copay / visit | |
| Inpatient Hospice | $0 copay / admission | |
| Outpatient Surgical Procedures (Hospital Facility) | $100 copay / visit | |
| Outpatient Surgical Procedures (Ambulatory Surgery Center) | $100 copay / visit | |
| Outpatient Surgical Procedures: Physician/Surgeon Fees | $0 copay / visit | |
| Skilled Nursing Facility | $0 copay / admission | Semi-private room, per admission<br>Up to 45 days per contract year |
| **Diagnostic Testing Services** | | |
| Laboratory Testing | $0 copay / visit | |
| EKG | Adult: $10/$20 copay / visit<br>Child: $0/$20 copay / visit | |
| Routine Radiology | Office:<br>Adult: $20 copay / visit<br>Child: $0/$20 copay / visit<br>Hospital: $40 copay / visit | |
| Advanced Radiology | Office: $20 copay / visit<br>Hospital: $40 copay / visit | 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 | No charge after the initial diagnosis.<br>Provided in accordance with USPSTF and HRSA guidelines |
| Inpatient Maternity | Delivery: $0 copay / admission<br>Physician: $0 copay / procedure | Semi-private room, per admission |
| **Mental Health & Substance Abuse** | | |
| Inpatient Mental Health | $0 copay / admission | Semi-private room, per admission |
| Outpatient Mental Health | Adult: $10 copay / visit<br>Child: $0 copay / visit | |
| Inpatient Substance Abuse - Rehab | $0 copay / admission | Semi-private room, per admission |
| Inpatient Substance Abuse - Detox | $0 copay / admission | Semi-private room, per admission |
| Outpatient Substance Abuse | Adult: $10 copay / visit<br>Child: $0 copay / visit | |


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| **Diabetic Supplies and Services** | | |
| Diabetic Equipment (e.g. Blood glucose monitor, etc.) | $0 copay | |
| Insulin and Other Oral Agents | $0 copay | Oral Agents at applicable cost share |
| Diabetic Medical Supplies (Test Strips, Syringes, etc.) | $0 copay | |
| **Rehabilitation Services** | | |
| Chiropractic Services | $20 copay / visit | |
| Physical - Occupational - Speech Therapies | $20 copay / visit | Up to 20 visits per contract year combined |
| Cardiac Rehabilitation | $20 copay / visit | |
| Pulmonary Rehabilitation | $20 copay / visit | |
| **Additional Services** | | |
| Durable Medical Equipment | 50% coinsurance | |
| Prosthetics and Appliances | 20% coinsurance | |
| Chemotherapy | Adult: $10/$20 copay / visit<br>Child: $0/$20 copay / visit | |
| Home Health Care | $20 copay / visit | Up to 40 visits per contract year |
| RedShirt Rewards | Earn up to $30 in rewards for covered members ages 18 and up per plan year for completing health related actions. | |
| Unique Benefits | $600 Single / $750 Family | To be used to pay for eligible health & wellness activities at participating Health Extras vendors |
| **Prescription Drug Coverage** | | |
| Prescription Plan | $5/$30/$60 with $0 for kids Tier 1 With Expanded Preventive Rx | Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary I. Cost-share, if applicable, does not apply to certain drugs. Visit our website to review our formulary. |
| Maintenance Medications | 2.5 copays for a 3 month supply | Mail Order: Must be obtained from ProAct or Wegmans.<br>Retail Pharmacy: Must be filled at a participating Pharmacy. |
| Medicare Part D Creditable Coverage Status | Creditable* | For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare. |


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| **Vision Services** | | |
| Medical Eye Exam | $20 copay / visit | |
| Routine/ Refractive Exam | $0 copay / visit | Once every 12 months |
| Standard Plastic Lenses | Single: $50<br>Bifocal: $70 | Contact EyeMed for additional options at 1-877-842-3348 |
| Frames | 40% discount | Discount is based on retail pricing |
| Conventional Contact Lenses | 15% discount | Materials only |
| Laser Vision Correction | 15% discount | Discount is based on standard pricing |
| **Dental Services** | | |
| Preventive and Routine | Not Covered | |
| Accidental Dental | Based on services rendered | Must be deemed medically necessary |
| **Dependent Coverage** | | |
| Dependent Eligibility | 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 max must be met before Independent Health provides reimbursement for coveredin-network or out-of-network services. On a family policy, once a family member meets the single deductible/out-of-pocket max, the deductible/out-of-pocket max is satisfied for that member. However, additional family members must satisfy the remainder of the family deductible/out-of-pocket maxbefore Independent Health provides reimbursement for covered in-network or out-of-network services.

Non-Embedded (True Family): On a single policy, the single deductible/out-of-pocket max must be met before Independent Health providesreimbursement for covered in-network or out-of-network services. On a family policy, the entire family deductible/out-of-pocket max must be metbefore Independent Health provides reimbursement for covered in-network or out-of-network services. An individual on a family policy will NOT stop atthe single deductible/out-of-pocket max.

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

PCP requirement is based on benefit plan type: POS Plan Type = PCP Required or PPO Plan Type = PCP Optional

Member Pre-Authorization: Certain services and benefits are subject to member pre-authorization. Member is responsible for contacting IndependentHealth 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 contractand 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