



## Benefit Summary

Plan Name:	Standard Gold	
Benefits	In-Network	Additional Information
<b>General Information</b>		
Deductible	\$600 / \$1,200	Where a deductible applies it accumulates as embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	
Out-of-Pocket Maximum	\$7,900 / \$15,800	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
Annual Maximum	Not Applicable	
Lifetime Maximum	Not Applicable	
<b>Preventive Services</b>		
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	All preventive services are covered in full with \$0 member liability when performed by a participating provider. See <a href="http://independenthealth.com">independenthealth.com</a> for additional information.
<b>Physician and Other Services</b>		
Primary Office Visit	Deductible then \$25 copay / visit	PCP Required
Specialist Office Visit	Deductible then \$40 copay / visit	
Allergy Testing & Treatment	Deductible then \$25/\$40 copay / visit	
Outpatient Surgical Procedures (in physician's office)	Deductible then \$25/\$40 copay / visit	
Telemedicine - General Medical Services	\$0 copay / consultation	Administered by Teladoc
Telemedicine - Behavioral Health Services	\$0 copay / consultation	Administered by Teladoc
Telemedicine Dermatology	Deductible then \$40 copay / consultation	Administered by Teladoc
<b>Emergency &amp; Urgent Care Services</b>		
Emergency Room	Deductible then \$150 copay / visit	Copay waived if admitted
Ambulance	Deductible then \$150 copay / trip	Must be deemed medically necessary
Urgent Care Center	Deductible then \$60 copay / visit	



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<b>Hospital and Other Facility Services</b>		
Inpatient Hospital	Deductible then \$1,000 copay / admission	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then \$100 copay / visit	
Inpatient Hospice	Deductible then \$1,000 copay / admission	Up to 210 days per plan year
Outpatient Surgical Procedures (Hospital Facility)	Deductible then \$100 copay / visit	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	Deductible then \$100 copay / visit	
Outpatient Surgical Procedures: Physician/Surgeon Fees	Deductible then \$100 copay / visit	
Skilled Nursing Facility	Deductible then \$1,000 copay / admission	Semi-private room, per admission Unlimited days per plan year
<b>Diagnostic Testing Services</b>		
Laboratory Testing	Deductible then \$40 copay / visit	
EKG	Deductible then \$25/\$40 copay / visit	
Routine Radiology	Deductible then \$40 copay / visit	
Advanced Radiology	Deductible then \$40 copay / visit	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.
<b>Maternity Services</b>		
Physician Services: Prenatal and Postnatal Care	\$0 copay / visit	In-Network Deductible does not apply No charge after the initial diagnosis. Provided in accordance with USPSTF and HRSA guidelines
Inpatient Maternity	Delivery: Deductible then \$1,000 copay / admission Physician: Deductible then \$100 copay / procedure	Semi-private room, per admission
<b>Mental Health &amp; Substance Abuse</b>		
Inpatient Mental Health	Deductible then \$1,000 copay / admission	Semi-private room, per admission
Outpatient Mental Health	Deductible then \$25 copay / visit	
Inpatient Substance Abuse - Rehab	Deductible then \$1,000 copay / admission	Semi-private room, per admission
Inpatient Substance Abuse - Detox	Deductible then \$1,000 copay / admission	Semi-private room, per admission
Outpatient Substance Abuse	Deductible then \$25 copay / visit	



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<b>Diabetic Supplies and Services</b>		
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	Deductible then \$25 copay	
Insulin and Other Oral Agents	\$0 copay	Oral Agents at applicable cost share
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	Deductible then \$25 copay	
<b>Rehabilitation Services</b>		
Chiropractic Services	Deductible then \$40 copay / visit	
Physical - Occupational - Speech Therapies	Deductible then \$30 copay / visit	60 visits per condition, per plan year combined therapies
Cardiac Rehabilitation	Deductible then \$25 copay / visit	
Pulmonary Rehabilitation	Deductible then \$25 copay / visit	
<b>Additional Services</b>		
Durable Medical Equipment	Deductible then 20% coinsurance	
Prosthetics and Appliances	Deductible then 20% coinsurance	
Chemotherapy Visits	Deductible then \$25 copay / visit	See Medications Administered in an Office or Outpatient Hospital Setting for additional member liability
Medications Administered in an Office or Outpatient Hospital Setting	Deductible then \$0 copay / visit	Excludes Allergy Injections
Home Health Care	Deductible then \$25 copay / visit	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.	
Unique Benefits	Health Extras: \$250 allowance per Plan Year or Nutrition Reimbursement: Up to \$500 per individual/\$1,000 per family	After your effective date you must choose either Health Extras or Nutrition Reimbursement
<b>Prescription Drug Coverage</b>		
Prescription Plan	\$10/\$35/\$70	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary II.  Cost-share, if applicable, does not apply to certain prescription drugs. Visit our website to review our formulary.
Maintenance Medications	Mail Order: 2.5 copays for a 3 month supply, Deductible may apply Retail: 3 copays for a 3 month supply, Deductible may apply	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*	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.



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<b>Pediatric Vision Services</b>		
Medical Eye Exam	Deductible then \$40 copay / visit	
Routine/ Refractive Exam	Deductible then \$25 copay / visit	Once every 12 months
Standard Plastic Lenses	Deductible then 20% coinsurance	Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
Frames	Deductible then 20% coinsurance	Once every 12 months
Conventional Contact Lenses	Deductible then 20% coinsurance	Once every 12 months. In lieu of frames/lenses. Materials only.
Laser Vision Correction	15% off retail price or 5% off promotional price	
<b>Adult Vision Services</b>		
Medical Eye Exam	Deductible then \$40 copay / visit	
Routine/ Refractive Exam	\$40 copay / visit	Once every 12 months
Standard Plastic Lenses	Single: \$50 Bifocal: \$70	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% off most retail frames	
Conventional Contact Lenses	15% off retail price	Materials only
Laser Vision Correction	15% off retail price or 5% off promotional price	
<b>Dental Services</b>		
Preventive and Routine	Not Covered	
Accidental Dental	Based on services rendered	Must be deemed medically necessary
<b>Dependent Coverage</b>		
Dependent Eligibility	26	Up to the end of the birthday month



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### 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.