Benefit Summary

Plan Name:	iDirect Gold Copay	
Benefits	**In-Network**	**Additional Information**
General Information		
Deductible	$1,250 / $2,500	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	
Out-of-Pocket Maximum	$6,750 / $13,500	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	
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	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	PCP Required. In-Network Deductible does not apply
Specialist Office Visit	Deductible then $50 copay / visit	
Allergy Testing & Treatment	$20/Deductible then $50 copay / visit	
Outpatient Surgical Procedures (in physician's office)	$20/Deductible then $50 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 $50 copay / consultation	Administered by Teladoc
Emergency & Urgent Care Services		
Emergency Room	Deductible then $300 copay / visit	Copay waived if admitted
Ambulance	Deductible then $150 copay / trip	Must be deemed medically necessary
Urgent Care Center	$75 copay / visit	In-Network Deductible does not apply

Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay	
Benefits	**In-Network**	**Additional Information**
Hospital and Other Facility Services		
Inpatient Hospital	Deductible then $1,000 copay / admission	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay / visit	
Inpatient Hospice	Deductible then $0 copay / admission	Up to 210 days per plan year
Outpatient Surgical Procedures (Hospital Facility)	Deductible then $200 copay / visit	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	Deductible then $150 copay / visit	
Outpatient Surgical Procedures: Physician/Surgeon Fees	Deductible then $0 copay / visit	
Skilled Nursing Facility	Deductible then $1,000 copay / admission	Semi-private room, per admission Unlimited days per plan year
Diagnostic Testing Services		
Laboratory Testing	Deductible then $20 copay / visit	
EKG	$20/Deductible then $50 copay / visit	
Routine Radiology	Deductible then $50 copay / visit	
Advanced Radiology	Deductible then $85 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	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 $0 copay / procedure	Semi-private room, per admission
Mental Health & Substance Abuse		
Inpatient Mental Health	Deductible then $1,000 copay / admission	Semi-private room, per admission
Outpatient Mental Health	$20 copay / visit	In-Network Deductible does not apply
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	$20 copay / visit	

Benefit Summary

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Benefits	**In-Network**	**Additional Information**
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	Deductible then $50 copay / visit	
Physical - Occupational - Speech Therapies	Deductible then $50 copay / visit	60 visits per condition, per plan year combined therapies
Cardiac Rehabilitation	Deductible then $50 copay / visit	
Pulmonary Rehabilitation	Deductible then $50 copay / visit	
Additional Services		
Durable Medical Equipment	Deductible then 50% coinsurance	
Prosthetics and Appliances	Deductible then 50% coinsurance	
Chemotherapy Visits	$20/Deductible then $50 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	20% coinsurance / Deductible then 20% coinsurance	Excludes Allergy Injections
Home Health Care	Deductible then $50 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
Prescription Drug Coverage		
Prescription Plan	$10/$40/50%	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	2.5 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.

Independent Health

Benefit Summary

Plan Name:	iDirect Gold Copay	
Benefits	**In-Network**	**Additional Information**
Pediatric Vision Services		
Medical Eye Exam	Deductible then $50 copay / visit	
Routine/ Refractive Exam	$20 copay / visit	In-Network Deductible does not apply Once every 12 months.
Standard Plastic Lenses	30% coinsurance	In-Network Deductible does not apply. Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
Frames	30% coinsurance	Once every 12 months
Conventional Contact Lenses	30% coinsurance	Once every 12 months. In lieu of frames/lenses. Materials only.
Laser Vision Correction	15% off retail price or 5% off promotional price	
Adult Vision Services		
Medical Eye Exam	Deductible then $50 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	
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

Benefit Summary

Plan Name:	iDirect Gold Copay

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.