



## Benefit Summary

| Plan Name:                                                                                                                                                                                                                                                                                                                                                  | FlexFit Platinum         |                                 |                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                                                                                                                                                                                                                                                                                                                                    | In-Network               | Out-of-Network                  | Additional Information                                                                                                                                                  |
| <b>General Information</b>                                                                                                                                                                                                                                                                                                                                  |                          |                                 |                                                                                                                                                                         |
| Deductible                                                                                                                                                                                                                                                                                                                                                  | \$0                      | \$5,000 / \$10,000              | Where a deductible applies it accumulates as non-embedded.<br>*See Important Notes section for more detail.                                                             |
| Coinsurance                                                                                                                                                                                                                                                                                                                                                 | Applies Where Indicated  | 20%                             |                                                                                                                                                                         |
| Out-of-Pocket Maximum                                                                                                                                                                                                                                                                                                                                       | \$6,000 / \$12,000       | \$10,000 / \$20,000             | Where the out of pocket max applies it accumulates as embedded.<br>*See Important Notes section for more detail.                                                        |
| Annual Maximum                                                                                                                                                                                                                                                                                                                                              | Not Applicable           | Not Applicable                  |                                                                                                                                                                         |
| Lifetime Maximum                                                                                                                                                                                                                                                                                                                                            | Not Applicable           | Not Applicable                  |                                                                                                                                                                         |
| <b>Preventive Services</b>                                                                                                                                                                                                                                                                                                                                  |                          |                                 |                                                                                                                                                                         |
| 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                      | Deductible then 20% coinsurance | All preventive services are covered in full with \$0 member liability when performed by a participating provider. See independenthealth.com for additional information. |
| <b>Physician and Other Services</b>                                                                                                                                                                                                                                                                                                                         |                          |                                 |                                                                                                                                                                         |
| Primary Office Visit                                                                                                                                                                                                                                                                                                                                        | \$10 copay / visit       | Deductible then 20% coinsurance | No copay for first 3 visits                                                                                                                                             |
| Specialist Office Visit                                                                                                                                                                                                                                                                                                                                     | \$40 copay / visit       | Deductible then 20% coinsurance |                                                                                                                                                                         |
| Allergy Testing & Treatment                                                                                                                                                                                                                                                                                                                                 | \$10/\$40 copay / visit  | Deductible then 20% coinsurance |                                                                                                                                                                         |
| Outpatient Surgical Procedures (in physician's office)                                                                                                                                                                                                                                                                                                      | \$10/\$40 copay / visit  | Deductible then 20% 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                                                                                                                                                                                                                                                                                                                                  | \$0 copay / consultation | Not Covered                     | Administered by Teladoc                                                                                                                                                 |



## Benefit Summary

| Plan Name:                                                 | FlexFit Platinum                                                      |                                 |                                                                                                                                     |
|------------------------------------------------------------|-----------------------------------------------------------------------|---------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                                   | In-Network                                                            | Out-of-Network                  | Additional Information                                                                                                              |
| <b>Emergency &amp; Urgent Care Services</b>                |                                                                       |                                 |                                                                                                                                     |
| Emergency Room                                             | \$250 copay / visit                                                   | \$250 copay / visit             | Copay waived if admitted                                                                                                            |
| Ambulance                                                  | \$150 copay / trip                                                    | \$150 copay / trip              | Must be deemed medically necessary                                                                                                  |
| Urgent Care Center                                         | \$100 copay / visit                                                   | \$100 copay / visit             |                                                                                                                                     |
| <b>Hospital and Other Facility Services</b>                |                                                                       |                                 |                                                                                                                                     |
| Inpatient Hospital                                         | \$750 copay / admission                                               | Deductible then 20% coinsurance | Semi-private room, per admission                                                                                                    |
| Inpatient Hospital: Physician/Surgeon Fees                 | \$0 copay / visit                                                     | Deductible then 20% coinsurance |                                                                                                                                     |
| Inpatient Hospice                                          | \$0 copay / admission                                                 | Deductible then 20% coinsurance | Up to 210 days per plan year                                                                                                        |
| Outpatient Surgical Procedures (Hospital Facility)         | \$300 copay / visit                                                   | Deductible then 20% coinsurance |                                                                                                                                     |
| Outpatient Surgical Procedures (Ambulatory Surgery Center) | \$250 copay / visit                                                   | Deductible then 20% coinsurance |                                                                                                                                     |
| Outpatient Surgical Procedures: Physician/Surgeon Fees     | \$0 copay / visit                                                     | Deductible then 20% coinsurance |                                                                                                                                     |
| Skilled Nursing Facility                                   | \$750 copay / admission                                               | Deductible then 20% coinsurance | Semi-private room, per admission<br>Unlimited days per plan year                                                                    |
| <b>Diagnostic Testing Services</b>                         |                                                                       |                                 |                                                                                                                                     |
| Laboratory Testing                                         | \$10 copay / visit                                                    | Deductible then 20% coinsurance |                                                                                                                                     |
| EKG                                                        | \$10/\$40 copay / visit                                               | Deductible then 20% coinsurance |                                                                                                                                     |
| Routine Radiology                                          | \$40 copay / visit                                                    | Deductible then 20% coinsurance |                                                                                                                                     |
| Advanced Radiology                                         | \$85 copay / visit                                                    | Deductible then 20% coinsurance | 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                                                     | Deductible then 20% coinsurance | No charge after the initial diagnosis.<br>Provided in accordance with USPSTF and HRSA guidelines                                    |
| Inpatient Maternity                                        | Delivery: \$750 copay / admission<br>Physician: \$0 copay / procedure | Deductible then 20% coinsurance | Semi-private room, per admission                                                                                                    |



## Benefit Summary

| Plan Name:                                                           | FlexFit Platinum                                                                                                             |                                 |                                                                                                          |
|----------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------|----------------------------------------------------------------------------------------------------------|
| Benefits                                                             | In-Network                                                                                                                   | Out-of-Network                  | Additional Information                                                                                   |
| <b>Mental Health &amp; Substance Abuse</b>                           |                                                                                                                              |                                 |                                                                                                          |
| Inpatient Mental Health                                              | \$750 copay / admission                                                                                                      | Deductible then 20% coinsurance | Semi-private room, per admission                                                                         |
| Outpatient Mental Health                                             | \$10 copay / visit                                                                                                           | Deductible then 20% coinsurance | No copay for first 3 visits                                                                              |
| Inpatient Substance Abuse - Rehab                                    | \$750 copay / admission                                                                                                      | Deductible then 20% coinsurance | Semi-private room, per admission                                                                         |
| Inpatient Substance Abuse - Detox                                    | \$750 copay / admission                                                                                                      | Deductible then 20% coinsurance | Semi-private room, per admission                                                                         |
| Outpatient Substance Abuse                                           | \$10 copay / visit                                                                                                           | Deductible then 20% coinsurance | No copay for first 3 visits                                                                              |
| <b>Diabetic Supplies and Services</b>                                |                                                                                                                              |                                 |                                                                                                          |
| Diabetic Equipment (e.g. Blood glucose monitor, etc.)                | \$0 copay                                                                                                                    | Deductible then 20% coinsurance |                                                                                                          |
| Insulin and Other Oral Agents                                        | \$0 copay                                                                                                                    | Deductible then 20% coinsurance | Oral Agents at applicable cost share                                                                     |
| Diabetic Medical Supplies (Test Strips, Syringes, etc.)              | \$0 copay                                                                                                                    | Deductible then 20% coinsurance |                                                                                                          |
| <b>Rehabilitation Services</b>                                       |                                                                                                                              |                                 |                                                                                                          |
| Chiropractic Services                                                | \$40 copay / visit                                                                                                           | Deductible then 20% coinsurance |                                                                                                          |
| Physical - Occupational - Speech Therapies                           | \$40 copay / visit                                                                                                           | Deductible then 20% coinsurance | 60 visits per condition, per plan year combined therapies                                                |
| Cardiac Rehabilitation                                               | \$40 copay / visit                                                                                                           | Deductible then 20% coinsurance |                                                                                                          |
| Pulmonary Rehabilitation                                             | \$40 copay / visit                                                                                                           | Deductible then 20% coinsurance |                                                                                                          |
| <b>Additional Services</b>                                           |                                                                                                                              |                                 |                                                                                                          |
| Durable Medical Equipment                                            | 50% coinsurance                                                                                                              | Deductible then 20% coinsurance |                                                                                                          |
| Prosthetics and Appliances                                           | 50% coinsurance                                                                                                              | Deductible then 20% coinsurance |                                                                                                          |
| Chemotherapy Visits                                                  | \$10/\$40 copay / visit                                                                                                      | Deductible then 20% 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 20% coinsurance | Excludes Allergy Injections                                                                              |
| Home Health Care                                                     | \$40 copay / visit                                                                                                           | Deductible then 20% 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<br>or<br>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:                                 | FlexFit Platinum                                      |                                 |                                                                                                                                                                                                                       |
|--------------------------------------------|-------------------------------------------------------|---------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Benefits                                   | In-Network                                            | Out-of-Network                  | Additional Information                                                                                                                                                                                                |
| <b>Prescription Drug Coverage</b>          |                                                       |                                 |                                                                                                                                                                                                                       |
| Prescription Plan                          | \$10/\$50/50%                                         | Not Covered                     | Must be filled at a participating Pharmacy.<br>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 | Not Covered                     | 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*                                           | Not Applicable                  | For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.                                                                                         |
| <b>Pediatric Vision Services</b>           |                                                       |                                 |                                                                                                                                                                                                                       |
| Medical Eye Exam                           | \$40 copay / visit                                    | Deductible then 20% coinsurance |                                                                                                                                                                                                                       |
| Routine/ Refractive Exam                   | \$20 copay / visit                                    | Not Covered                     | Once every 12 months                                                                                                                                                                                                  |
| Standard Plastic Lenses                    | 30% coinsurance                                       | Not Covered                     | Once every 12 months.<br>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.<br>In lieu of frames/lenses. Materials only.                                                                                                                                                    |
| Laser Vision Correction                    | 15% off retail price or 5% off promotional price      | Not Covered                     |                                                                                                                                                                                                                       |
| <b>Adult Vision Services</b>               |                                                       |                                 |                                                                                                                                                                                                                       |
| Medical Eye Exam                           | \$40 copay / visit                                    | Deductible then 20% coinsurance |                                                                                                                                                                                                                       |
| Routine/ Refractive Exam                   | \$40 copay / visit                                    | Not Covered                     | Once every 12 months                                                                                                                                                                                                  |
| Standard Plastic Lenses                    | Single: \$50<br>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                     |                                                                                                                                                                                                                       |
| <b>Dental Services</b>                     |                                                       |                                 |                                                                                                                                                                                                                       |
| Preventive and Routine                     | Not Covered                                           | Not Covered                     |                                                                                                                                                                                                                       |
| Accidental Dental                          | Based on services rendered                            | Based on services rendered      | Must be deemed medically necessary                                                                                                                                                                                    |



## Benefit Summary

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| Plan Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | FlexFit Platinum |                |                                     |
| Benefits                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | In-Network       | Out-of-Network | Additional Information              |
| <b>Dependent Coverage</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |                |                                     |
| Dependent Eligibility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 26               | 26             | Up to the end of the birthday month |
| <b>Important Notes</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |                |                                     |
| <p>Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.</p> <p>Embedded: On a single policy, the single deductible/out-of-pocket max must be met before Independent Health provides reimbursement for covered in-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 max before Independent Health provides reimbursement for covered in-network or out-of-network services.</p> <p>Non-Embedded (True Family): On a single policy, the single deductible/out-of-pocket max must be met before Independent Health provides reimbursement for covered in-network or out-of-network services. On a family policy, the entire family deductible/out-of-pocket max must be met before Independent Health provides reimbursement for covered in-network or out-of-network services. An individual on a family policy will NOT stop at the single deductible/out-of-pocket max.</p> <p>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.</p> <p>PCP requirement is based on benefit plan type: POS Plan Type = PCP Required or PPO Plan Type = PCP Optional</p> <p>Member Pre-Authorization: Certain services and benefits are subject to member pre-authorization. Member is responsible for contacting Independent Health for pre-authorization.</p> <p>Child (if applicable): Cost-share applies if member is under the age of 19.</p> <p>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.</p> <p>All indicated benefits assume the member has appropriate authorization to receive services.</p> <p>Certain benefits stated in this benefit summary may be pending NYS approval</p> |                  |                |                                     |