



## Benefit Summary

| Plan Name:  | iDirect Silver Copay HSAQ                 |                                 |  |
|---|---|---------------------------------|--|
| Benefits  | In-Network                                | Out-of-Network                  | Additional Information   |
| <b>General Information</b>  |   |                                 |  |
| Deductible  | \$2,000 / \$4,000                         | \$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                   | 50%                             |  |
| Out-of-Pocket Maximum   | \$7,500 / \$15,000                        | Unlimited                       | 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 50% coinsurance | 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 \$35 copay / visit        | Deductible then 50% coinsurance | PCP Required   |
| Specialist Office Visit   | Deductible then \$60 copay / visit        | Deductible then 50% coinsurance |  |
| Allergy Testing & Treatment   | Deductible then \$35/\$60 copay / visit   | Deductible then 50% coinsurance |  |
| Outpatient Surgical Procedures (in physician's office)  | Deductible then \$35/\$60 copay / visit   | Deductible then 50% coinsurance |  |
| Telemedicine - General Medical Services   | Deductible then \$0 copay / consultation  | Not Covered                     | Administered by Teladoc  |
| Telemedicine - Behavioral Health Services   | Deductible then \$0 copay / consultation  | Not Covered                     | Administered by Teladoc  |
| Telemedicine Dermatology  | Deductible then \$60 copay / consultation | Not Covered                     | Administered by Teladoc  |



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| <b>Emergency &amp; Urgent Care Services</b>                |   |                                     |   |
| Emergency Room   | Deductible then \$250 copay / visit   | Deductible then \$250 copay / visit | Copay waived if admitted  |
| Ambulance  | Deductible then \$250 copay / trip  | Deductible then \$250 copay / trip  | Must be deemed medically necessary  |
| Urgent Care Center   | Deductible then \$75 copay / visit  | Deductible then \$75 copay / visit  |   |
| <b>Hospital and Other Facility Services</b>                |   |                                     |   |
| Inpatient Hospital   | Deductible then \$1,000 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 \$200 copay / visit   | Deductible then 50% coinsurance     |   |
| Outpatient Surgical Procedures (Ambulatory Surgery Center) | Deductible then \$175 copay / visit   | Deductible then 50% coinsurance     |   |
| Outpatient Surgical Procedures: Physician/Surgeon Fees     | Deductible then \$150 copay / visit   | Deductible then 50% coinsurance     |   |
| Skilled Nursing Facility                                   | Deductible then \$1,000 copay / admission   | Deductible then 50% coinsurance     | Semi-private room, per admission<br>Unlimited days per plan year  |
| <b>Diagnostic Testing Services</b>                         |   |                                     |   |
| Laboratory Testing   | Deductible then \$35 copay / visit  | Deductible then 50% coinsurance     |   |
| EKG  | Deductible then \$35/\$60 copay / visit   | Deductible then 50% coinsurance     |   |
| Routine Radiology  | Deductible then \$60 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. |
| <b>Maternity Services</b>                                  |   |                                     |   |
| Physician Services: Prenatal and Postnatal Care            | \$0 copay / visit   | Deductible then 50% coinsurance     | In-Network Deductible does not apply<br>No charge after the initial diagnosis   |
| Inpatient Maternity  | Delivery: Deductible then \$1,000 copay / admission<br>Physician: Deductible then \$0 copay / procedure | Deductible then 50% coinsurance     | Semi-private room, per admission  |



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| <b>Mental Health &amp; Substance Abuse</b>                           |  |                                 |  |
| Inpatient Mental Health  | Deductible then \$1,000 copay / admission  | Deductible then 50% coinsurance | Semi-private room, per admission   |
| Outpatient Mental Health   | Deductible then \$35 copay / visit   | Deductible then 50% coinsurance |  |
| Inpatient Substance Abuse - Rehab                                    | Deductible then \$1,000 copay / admission  | Deductible then 50% coinsurance | Semi-private room, per admission   |
| Inpatient Substance Abuse - Detox                                    | Deductible then \$1,000 copay / admission  | Deductible then 50% coinsurance | Semi-private room, per admission   |
| Outpatient Substance Abuse   | Deductible then \$35 copay / visit   | Deductible then 50% coinsurance |  |
| <b>Diabetic Supplies and Services</b>                                |  |                                 |  |
| Diabetic Equipment (e.g. Blood glucose monitor, etc.)                | \$0 copay  | Deductible then 50% coinsurance |  |
| Insulin and Other Oral Agents  | \$35 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 |  |
| <b>Rehabilitation Services</b>                                       |  |                                 |  |
| Chiropractic Services  | Deductible then \$60 copay / visit   | Deductible then 50% coinsurance |  |
| Physical - Occupational - Speech Therapies                           | Deductible then \$60 copay / visit   | Deductible then 50% coinsurance | 60 visits per condition, per plan year combined therapies  |
| Cardiac Rehabilitation   | Deductible then \$60 copay / visit   | Deductible then 50% coinsurance |  |
| Pulmonary Rehabilitation   | Deductible then \$60 copay / visit   | Deductible then 50% coinsurance |  |
| <b>Additional Services</b>   |  |                                 |  |
| Durable Medical Equipment  | Deductible then 50% coinsurance  | Deductible then 50% coinsurance |  |
| Prosthetics and Appliances   | Deductible then 50% coinsurance  | Deductible then 50% coinsurance |  |
| Chemotherapy Visits  | Deductible then \$35/\$60 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 | Deductible then 20% coinsurance  | Deductible then 50% coinsurance | Excludes Allergy Injections  |
| Home Health Care   | Deductible then \$60 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<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                |



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| <b>Prescription Drug Coverage</b>          |   |                                 |   |
| Prescription Plan                          | Deductible then \$15/\$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                           | Deductible then \$60 copay / visit                    | Deductible then 50% 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.<br>Materials only.   |
| Laser Vision Correction                    | 15% off retail price or 5% off promotional price      | Not Covered                     |   |
| <b>Adult Vision Services</b>               |   |                                 |   |
| Medical Eye Exam                           | Deductible then \$60 copay / visit                    | Deductible then 50% 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  |



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