Independent Health
Dedicated to Making a Difference

511 Farber Lakes Drive, Buffalo, New York 14221 716 631 3001 www.independenthealth.com

Prepared by: Nick Barone
Benefit Consultant

Group Name: Southern Tier Environments for Living
21650

Benefit Summary

	iDirect 3 Series 5000-30		
	In-Network	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$5,000 Single/$10,000 Family Combined In and Out-of-Network	$5,000 Single/$10,000 Family Combined In and Out-of-Network	Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.
Coinsurance	Applies Where Indicated	30%	
Out-of-Pocket Maximum	$5,000 Single/$10,000 Family	Unlimited	
Annual Maximum	Not Applicable	Not Applicable	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal and one postpartum visit Prostate test (Prostate Specific Antigen "PSA") Well child visit Well Woman visit	$0	Deductible then 30% coinsurance	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	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Specialist Office Visit	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Allergy Testing & Treatment	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Outpatient Surgical Procedures (in physician's office)	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Emergency & Urgent Care Services			
Emergency Room	Deductible then $0 copay/visit	Deductible then $0 copay/visit	
Ambulance	Deductible then $0 copay/trip	Deductible then $0 copay/trip	Must be deemed medically necessary
Participating After Hours Care Centers	Deductible then $0 copay/visit	Not Applicable	
Hospital Services			
Inpatient Hospital	Deductible then $0 copay/admission	Deductible then 30% coinsurance	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Inpatient Hospice	Deductible then $0 copay/admission	Deductible then 30% coinsurance	
Outpatient Surgical Procedures (Facility)	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Skilled Nursing Facility	Deductible then $0 copay/admission	Deductible then 30% coinsurance	Semi-private room, per admission

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Diagnostic Testing Services			
Laboratory Testing	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
EKG	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Routine Radiology	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Advanced Radiology	Deductible then $0 copay/visit	Deductible then 30% coinsurance	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	Deductible then 30% coinsurance	No charge after the initial diagnosis
Inpatient Maternity	Delivery: Deductible then $0 copay/admission Physician: Deductible then $0 copay/procedure	Deductible then 30% coinsurance	Semi-private room, per admission
Mental Health & Substance Abuse			
Inpatient Mental Health	Deductible then $0 copay/admission	Deductible then 30% coinsurance	Semi-private room, per admission
Outpatient Mental Health	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Inpatient Substance Abuse - Rehab	Deductible then $0 copay/admission	Deductible then 30% coinsurance	Semi-private room, per admission
Inpatient Substance Abuse - Detox	Deductible then $0 copay/admission	Deductible then 30% coinsurance	Semi-private room, per admission
Outpatient Substance Abuse	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	Deductible then $0 copay	Deductible then 30% coinsurance	
Insulin and Other Oral Agents	Deductible then $0 copay	Deductible then 30% coinsurance	
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	Deductible then $0 copay	Deductible then 30% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then $0 copay/visit	Deductible then 30% coinsurance	Up to 20 visits per contract year
Cardiac Rehabilitation	Deductible then $0 copay/visit	Deductible then 30% coinsurance	Up to 36 visits per event
Pulmonary Rehabilitation	Deductible then $0 copay/visit	Deductible then 30% coinsurance	Up to 24 visits per contract year
Additional Services			
Durable Medical Equipment	Deductible then $0	Deductible then 30% coinsurance	

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Additional Services			
Prosthetics and Appliances	Deductible then $0	Deductible then 50% coinsurance	
Chemotherapy	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Home Health Care	Deductible then $0 copay/visit	Deductible then 30% coinsurance	Up to 40 visits per contract year
Unique Benefits	$250 allowance	Not Applicable	To be used to pay for eligible health & wellness activities at participating personalBest vendors
Prescription Drug Coverage			
Prescription Plan	Deductible then $10/100%/100%	Not Covered	Must be filled at a participating Pharmacy
Maintenance Medications	Deductible then 2.5 copays for a 3 month supply	Not Covered	Mail Order: Must be obtained from Walgreens or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.
Medicare Part D Creditable Coverage Status	Not Creditable	Not Applicable	For those who are Medicare eligible, this plan does not meet the standard level of prescription drug coverage determined by Medicare, therefore this plan does not provide you with CREDITABLE COVERAGE
Vision Services			
Medical Eye Exam	Deductible then $0 copay/visit	Deductible then 30% coinsurance	
Routine/ Refractive Exam	$10 copay/visit	Not Covered	Once every 12 months
Standard Plastic Lenses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% discount	Not Covered	Discount is based on retail pricing
Conventional Contact Lenses	15% discount	Not Covered	Materials only
Laser Vision Correction	15% discount	Not Covered	Discount is based on standard pricing
Dental Services			
Preventive and Routine	Not Covered	Not Covered	
Accidental Dental	Based on services rendered	Based on services rendered	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month

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Important Notes

Out-of-Network: Member is responsible for the difference between Independent Health's allowed amount and the non-participating provider's billed amount.

Pre-Existing Conditions: Not Applicable.

Member Pre-Authorization/Pre-Certification: Certain services and benefits are subject to member pre-authorization/pre-certification. Member is responsible for contacting Independent Health for pre-authorization/pre-certification.

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 are pending NYS approval.