Independent Health
Dedicated to Making a Difference

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

Prepared by: Kari Wilson
Benefit Consultant

Group Name: SUB-BOARD I INC
P32043

Benefit Summary

	FlexFit Platinum		
	In-Network	**Out-of-Network**	**Additional Information**
General Information			
Deductible	Not Applicable	$2000/$4000	Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.
Coinsurance	Not Applicable	40%	
Out-of-Pocket Maximum	$5000/$10,000	Unlimited	
Annual Maximum	Not Applicable	Not Applicable	
Lifetime 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 40% 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	$10 copay/visit	Deductible then 40% coinsurance	$250 Primary Care Office Visit Allowance
Specialist Office Visit	$30 copay/visit	Deductible then 40% coinsurance	
Allergy Testing & Treatment	$10/$30 copay/visit	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (in physician's office)	$10/$30 copay/visit	Deductible then 40% coinsurance	
Emergency & Urgent Care Services			
Emergency Room	$150 copay/visit	$150 copay/visit	Copay waived if admitted
Ambulance	$150 copay/trip	$150 copay/trip	Must be deemed medically necessary
Urgent Care	$75 copay/visit	$75 copay/visit	
Hospital Services			
Inpatient Hospital	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	$0 copay	Deductible then 40% coinsurance	
Inpatient Hospice	$0 copay/admission	Deductible then 40% coinsurance	Up to 210 days per plan year
Outpatient Surgical Procedures (Facility)	$150 copay/visit	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	$30 copay/visit	Deductible then 40% coinsurance	
Skilled Nursing Facility	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission Up to 200 days per plan year

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Diagnostic Testing Services			
Laboratory Testing	$10 copay/visit	Deductible then 40% coinsurance	
EKG	$30 copay/visit	Deductible then 40% coinsurance	
Routine Radiology	$30 copay/visit	Deductible then 40% coinsurance	
Advanced Radiology	$75 copay/visit	Deductible then 40% 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 40% coinsurance	No charge after the initial diagnosis
Inpatient Maternity	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission
Mental Health & Substance Abuse			
Inpatient Mental Health	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission
Outpatient Mental Health	$10 copay/visit	Deductible then 40% coinsurance	
Inpatient Substance Abuse - Rehab	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission
Inpatient Substance Abuse - Detox	$500 copay/admission	Deductible then 40% coinsurance	Semi-private room, per admission
Outpatient Substance Abuse	$10 copay/visit	Deductible then 40% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$10 copay	Deductible then 40% coinsurance	
Insulin and Other Oral Agents	$10 copay	Deductible then 40% coinsurance	
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$10 copay	Deductible then 40% coinsurance	
Rehabilitation Services			
Chiropractic Services	$30 copay/visit	Deductible then 40% coinsurance	
Physical - Occupational - Speech Therapies	$30 copay/visit	Deductible then 40% coinsurance	Up to 60 visits combined per lifetime for all therapies
Cardiac Rehabilitation	$10 copay/visit	Deductible then 40% coinsurance	Up to 36 visits per event
Pulmonary Rehabilitation	$10 copay/visit	Deductible then 40% coinsurance	Up to 24 visits per plan year
Additional Services			
Durable Medical Equipment	50% coinsurance	Deductible then 50% coinsurance	
Prosthetics and Appliances	50% coinsurance	Deductible then 50% coinsurance	

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Additional Services			
Chemotherapy	$10/$30 copay/visit	Deductible then 40% coinsurance	
Home Health Care	$10 copay/visit	Deductible then 40% coinsurance	Up to 40 visits per plan year
Unique Benefits	Option 1: $250 gym/wellness services allowance. Option 2: Up to $500 per individual/$1,000 per family earned from the purchase of fresh produce.	Not Covered	After your effective date you must choose either Option 1 or Option 2. You and your Covered Spouse must complete a Well-Being assessment prior to receiving the benefit.
Prescription Drug Coverage			
Prescription Plan	$4/$30/50%	Not Covered	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary III.
Maintenance Medications	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	Creditable	Not Applicable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare, therefore this plan provides you with CREDITABLE COVERAGE.
Pediatric Vision Services			
Medical Eye Exam	$30 copay/visit	Deductible then 40% coinsurance	
Routine/ Refractive Exam	$20 copay	Not Covered	Once every 12 months
Standard Plastic Lenses	30% coinsurance	Not Covered	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. In lieu of frames/lenses. Materials only.
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Adult Vision Services			
Medical Eye Exam	$30 copay/visit	Deductible then 40% coinsurance	
Routine/ Refractive Exam	$5 off exam	Not Covered	
Standard Plastic Lenses	$50	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
Frames	35% off most retail frames	Not Covered	
Conventional Contact Lenses	15% off retail price	Not Covered	Materials only

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Adult Vision Services			
Laser Vision Correction	15% off retail price or 5% off promotional price	Not Covered	
Dental Services			
Preventive and Routine	Not Covered	Not Covered	
Accidental Dental	Based on services rendered	Deductible then 40% coinsurance	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month

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.