Independent Health

Account Name: WNY Dist of Wesleyan Church
Account #: 22997
Sales Representative: Alison Lytle
Plan Effective Date: January 1, 2018

Benefit Summary

Plan Name:	iDirect Silver Coinsurance HSAQ		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$2,500 / $5,000	$3,000 / $6,000	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	20%	40%	
Out-of-Pocket Maximum	$6,550 / $13,100	$10,000 / $20,000	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
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 Post-partum Visits 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	Deductible then 20% coinsurance	Deductible then 40% coinsurance	PCP Required
Specialist Office Visit	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Allergy Testing & Treatment	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (in physician's office)	Primary: Deductible then 20% coinsurance Specialist: Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Telemedicine Program	Deductible then $0 copay / consultation	Not Covered	
Emergency & Urgent Care Services			
Emergency Room	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Copay waived if admitted
Ambulance	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Must be deemed medically necessary
Urgent Care	Deductible then 20% coinsurance	Deductible then 20% coinsurance	

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Hospital Services			
Inpatient Hospital	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Inpatient Hospice	Deductible then $0 copay / visit	Deductible then 40% coinsurance	Up to 210 days per plan year
Outpatient Surgical Procedures (Facility)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Skilled Nursing Facility	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission Unlimited days per plan year
Diagnostic Testing Services			
Laboratory Testing	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
EKG	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Routine Radiology	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Advanced Radiology	Deductible then 20% coinsurance	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	Delivery: Deductible then 20% coinsurance Physician: Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission
Mental Health & Substance Abuse			
Inpatient Mental Health	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission
Outpatient Mental Health	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Inpatient Substance Abuse - Rehab	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission
Inpatient Substance Abuse - Detox	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Semi-private room, per admission
Outpatient Substance Abuse	Deductible then 20% coinsurance	Deductible then 40% coinsurance	

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Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Insulin and Other Oral Agents	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Office visit benefit or pharmacy rider benefit, whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 60 visits per condition per plan year
Cardiac Rehabilitation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 36 visits per event
Pulmonary Rehabilitation	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Up to 24 visits per plan year
Additional Services			
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 20% coinsurance	Deductible then 40% 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 40% coinsurance	Excludes Allergy Injections
Home Health Care	Deductible then 20% coinsurance	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.
Prescription Drug Coverage			
Prescription Plan	Deductible then $15/$50/50%	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, deductible may apply	Not Covered	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	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.

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Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Pediatric Vision Services			
Medical Eye Exam	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Routine/ Refractive Exam	$20 copay	Not Covered	Once every 12 months
Standard Plastic Lenses	30% coinsurance	Not Covered	Once every 12 months. 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	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
Routine/ Refractive Exam	$40 copay / visit	Not Covered	
Standard Plastic Lenses	Single: $50 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	
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

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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 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.

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.

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.

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.

Delta Dental PPO℠
Pediatric Basic Plan for Small Businesses

Plan Highlights	Pediatric Benefits (up to age 19)	
Deductibles & Maximums per Contract Year		
Deductible Per enrollee	$65	
Family	$195	
Deductible Waived for Diagnostic and Preventive Services	No	
Annual Maximum Maximum the plan will pay each year for services per person.	None	
Out-of-Pocket Maximum After this amount is reached, the plan pays 100% of the remaining covered services for that year. Applies only to in-network services.	$350 for one pediatric enrollee, $700 for two or more pediatric enrollees	
Covered Services[1,2]	*Delta Dental pays*	*Enrollee pays*
Diagnostic and Preventive Services	100%	0%
Basic Services	50%	50%
Major Services	50%	50%
Orthodontic Services Medically necessary (requires prior authorization)	50%	50%
Waiting Period(s)	None	

[1] Reimbursement to dentists is based on contracted fees. Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Please refer to your plan Policy or Evidence of Coverage for complete limitations and exclusions for this plan.

[2] Coverage may not be available in all areas. Service area coverage and/or restrictions are listed in the limitations and exclusions.

SCHEDULE OF BENEFITS

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT			
Deductible			The Deductible is a combined In-Network and Out-of-Network Deductible
• One (1) Member under Age 19	$65 each Plan Year	$65 each Plan Year	
• Two (2) or More Members under Age 19	$195 each Plan Year	$195 each Plan Year	
Out-of-Pocket Limit			
• One (1) Member under Age 19	$350 each Plan Year	Not Applicable	
• Two or More Members under Age 19	$700 each Plan Year	Not Applicable	
SUMMARY OF PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care			
• Emergency Dental Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Preventive Dental Care	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Two (2) Cleanings per Plan Year
• Routine Dental Care	0%-50% Coinsurance after Deductible	0%-50% Coinsurance after Deductible	Two (2) Dental Exams per Plan Year Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X- rays at six month intervals

• Endodontics • Periodontics • Prosthodontics • Oral Surgery • Orthodontics **Orthodontics require Preauthorization**	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Dental examinations and consultations	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Two (2) Dental Exams per Plan Year
• X-rays, full mouth x-rays or panoramic x-rays	0% Coinsurance after Deductible	0% Coinsurance after Deductible	Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X- rays at six month intervals
• Visits; Simple extractions and other routine dental surgery not requiring hospitalization; In-office conscious sedation; Amalgam, composite restorations and stainless steel crowns; Other restorative materials	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Temporomandibular Joint (TMJ) Dysfunction	50% Coinsurance after Deductible	50% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Contract, You will be responsible for the full cost of theservices.