Independent Health

Account Name: SUNY Research Foundation
Account #: 23011
Sales Representative: Gina Monteleone
Plan Effective Date: January 1, 2019

Benefit Summary

Plan Name:	Encompass C		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$0	$0/$0	Where a deductible applies it accumulates as embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	Not Covered	
Out-of-Pocket Maximum	$6,350 / $12,700	$0	Where the out of pocket max applies it accumulates as embedded. *See Important Notes section for more detail.
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 Post-partum Visits Prostate test (Prostate Specific Antigen "PSA") Well child visit Well Woman Visit	$0	Not Covered	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	$20 copay / visit	Not Covered	PCP Required
Specialist Office Visit	$20 copay / visit	Not Covered	
Allergy Testing & Treatment	$20 copay / visit	Not Covered	
Outpatient Surgical Procedures (in physician's office)	$20 copay / visit	Not Covered	
Telemedicine Including Mental Health, Behavioral Health and Substance Use Disorder	$0 copay / consultation	Not Covered	
Telemedicine Dermatology	$20 copay / consultation	Not Covered	
Emergency & Urgent Care Services			
Emergency Room	$125 copay / visit	Covered as an in-network benefit	Waived if admitted
Ambulance	$75 copay / trip	Covered as an in-network benefit	Must be deemed medically necessary
Urgent Care Center	$35 copay / visit	$35 copay / visit	

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Hospital and Other Facility Services			
Inpatient Hospital	$100 copay / admission	Not Covered	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	$0 copay / visit	Not Covered	
Inpatient Hospice	$0 copay / admission	Not Covered	
Outpatient Surgical Procedures (Hospital Facility)	$75 copay / visit	Not Covered	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	$50 copay / visit	Not Covered	
Outpatient Surgical Procedures: Physician/Surgeon Fees	$0 copay / visit	Not Covered	
Skilled Nursing Facility	$100 copay / admission	Not Covered	Semi-private room, per admission Up to 45 days per contract year
Diagnostic Testing Services			
Laboratory Testing	$0 copay / visit	Not Covered	
EKG	$20 copay / visit	Not Covered	
Routine Radiology	$20 copay / visit	Not Covered	
Advanced Radiology	$20 copay / visit	Not Covered	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	Not Covered	No charge after the initial diagnosis
Inpatient Maternity	Delivery: $100 copay / admission Physician: $0 copay/procedure	Not Covered	Semi-private room, per admission
Mental Health & Substance Abuse			
Inpatient Mental Health	$100 copay / admission	Not Covered	Semi-private room, per admission
Outpatient Mental Health	$20 copay / visit	Not Covered	
Inpatient Substance Abuse - Rehab	$100 copay / admission	Not Covered	Semi-private room, per admission
Inpatient Substance Abuse - Detox	$100 copay / admission	Not Covered	Semi-private room, per admission
Outpatient Substance Abuse	$20 copay / visit	Not Covered	

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Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$15 copay	Not Covered	
Insulin and Other Oral Agents	$15 copay	Not Covered	Office visit copay or pharmacy rider copay, whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$15 copay	Not Covered	
Rehabilitation Services			
Chiropractic Services	$20 copay / visit	Not Covered	
Physical - Occupational - Speech Therapies	$15 copay / visit	Not Covered	Up to 20 visits per contract year
Cardiac Rehabilitation	$20 copay / visit	Not Covered	Up to 36 visits per event
Pulmonary Rehabilitation	$15 copay / visit	Not Covered	Up to 24 visits per contract year
Additional Services			
Durable Medical Equipment	50% coinsurance	Not Covered	
Prosthetics and Appliances	50% coinsurance	Not Covered	
Chemotherapy	$20 copay / visit	Not Covered	
Home Health Care	$20 copay / visit	Not Covered	Up to 40 visits per contract year
Prescription Drug Coverage			
Prescription Plan	$10/$30/$50	Not Covered	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary I.
Maintenance Medications	2.5 copays for a 3 month supply	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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Vision Services			
Medical Eye Exam	$20 copay / visit	Not Covered	
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	Not Covered	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	26	26	Up to the end of the birthday month

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.

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.

Child (if applicable): Cost-share applies if member is under the age of 19.

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.