Independent Health

Account Name: NY Power Authority
Account #: 22637
Sales Representative: Brian Smith
Plan Effective Date: January 1, 2025

Benefit Summary

Plan Name:	FlexFit Active		
Benefits	**Active**	**Family**	**Additional Information**
General Information			
Deductible	In-Network: $0 Out-of-Network: $1,000 / $2,000	In-Network: $0 Out-of-Network: $1,000 / $2,000	Where a deductible applies it accumulates as embedded. *See Important Notes section for more detail.
Coinsurance	In-Network: Applies Where Indicated Out-of-Network: 20%	In-Network: Applies Where Indicated Out-of-Network: 20%	
Out-of-Pocket Maximum	In-Network: $6,350 / $12,700 Out-of-Network: $10,000 / $20,000	In-Network: $6,350 / $12,700 Out-of-Network: $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	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy Sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal visits Post-Partum visits Prostate test (Prostate Specific Antigen "PSA") Well-Child visit Well-Woman visit	$0	$0	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	Adult: $10 copay / visit Child: $25 copay / visit	Adult: $15 copay / visit Child: $0 copay / visit	PCP Required
Specialist Office Visit	Adult: $25 copay / visit Child: $25 copay / visit	Adult: $25 copay / visit Child: $25 copay / visit	
Allergy Testing & Treatment	Adult: $10/$25 copay / visit Child: $25 copay / visit	Adult: $15/$25 copay / visit Child: $0/$25 copay / visit	
Outpatient Surgical Procedures (in physician's office)	Adult: $10/$25 copay / visit Child: $25 copay / visit	Adult: $15/$25 copay / visit Child: $0/$25 copay / visit	
Telemedicine - General Medical Services	$0 copay / consultation	$0 copay / consultation	Administered by Teladoc
Telemedicine - Behavioral Health Services	$0 copay / consultation	$0 copay / consultation	Administered by Teladoc
Telemedicine - Dermatology	$25 copay / consultation	$25 copay / consultation	Administered by Teladoc

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Emergency & Urgent Care Services			
Emergency Room	$150 copay / visit	$150 copay / visit	Waived if admitted
Ambulance	$100 copay / trip	$100 copay / trip	Must be deemed medically necessary
Urgent Care Center	$35 copay / visit	$35 copay / visit	
Hospital and Other Facility Services			
Inpatient Hospital	$0 copay / admission	$0 copay / admission	Semi-private room, per admission
Inpatient Hospital: Physician/Surgeon Fees	$0 copay / visit	$0 copay / visit	
Inpatient Hospice	$0 copay / admission	$0 copay / admission	
Outpatient Surgical Procedures (Hospital Facility)	$150 copay / visit	$150 copay / visit	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	$125 copay / visit	$125 copay / visit	
Outpatient Surgical Procedures: Physician/Surgeon Fees	$0 copay / visit	$0 copay / visit	
Skilled Nursing Facility	$0 copay / admission	$0 copay / admission	Semi-private room, per admission Up to 45 days per contract year
Diagnostic Testing Services			
Laboratory Testing	$0 copay / visit	$0 copay / visit	
EKG	Adult: $10/$25 copay / visit Child: $25 copay / visit	Adult: $15/$25 copay / visit Child: $0/$25 copay / visit	
Routine Radiology	$25 copay / visit	Adult: $25 copay / visit Child: $0/$25 copay / visit	
Advanced Radiology	$25 copay / visit	$25 copay / visit	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	Adult: $0 copay / visit Child: $0 copay / visit	Adult: $0 copay / visit Child: $0 copay / visit	No charge after the initial diagnosis. Provided in accordance with USPSTF and HRSA guidelines
Inpatient Maternity	Delivery: $0 copay / admission Physician: $0 copay / procedure	Delivery: $0 copay / admission Physician: $0 copay / procedure	Semi-private room, per admission

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Mental Health & Substance Abuse			
Inpatient Mental Health	$0 copay / admission	$0 copay / admission	Semi-private room, per admission
Outpatient Mental Health	Adult: $10 copay / visit Child: $0 copay / visit	Adult: $15 copay / visit Child: $0 copay / visit	
Inpatient Substance Abuse - Rehab	$0 copay / admission	$0 copay / admission	Semi-private room, per admission
Inpatient Substance Abuse - Detox	$0 copay / admission	$0 copay / admission	Semi-private room, per admission
Outpatient Substance Abuse	Adult: $10 copay / visit Child: $0 copay / visit	Adult: $15 copay / visit Child: $0 copay / visit	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$0 copay	$0 copay	
Insulin and Other Oral Agents	$0 copay	$0 copay	Oral Agents at applicable cost share
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 copay	$0 copay	
Rehabilitation Services			
Chiropractic Services	$25 copay / visit	$25 copay / visit	
Physical - Occupational - Speech Therapies	$25 copay / visit	$25 copay / visit	Up to 20 visits per contract year combined
Cardiac Rehabilitation	$25 copay / visit	$25 copay / visit	
Pulmonary Rehabilitation	$25 copay / visit	$25 copay / visit	
Additional Services			
Durable Medical Equipment	20% coinsurance	20% coinsurance	
Prosthetics and Appliances	20% coinsurance	20% coinsurance	
Chemotherapy	Adult: $10/$25 copay / visit Child: $25 copay / visit	Adult: $15/$25 copay / visit Child: $0/$25 copay / visit	
Home Health Care	$25 copay / visit	$25 copay / visit	Up to 40 visits per contract year
RedShirt Rewards	Earn up to $30 in rewards for covered members ages 18 and up per plan year for completing health related actions.	Earn up to $30 in rewards for covered members ages 18 and up per plan year for completing health related actions.	
Unique Benefits	$250 allowance	$250 allowance	To be used to pay for eligible health & wellness activities at participating Health Extras vendors

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Prescription Drug Coverage			
Prescription Plan	$4/$15/$30	$4/$15/$30	Must be filled at a participating Pharmacy. This plan utilizes Prescription Drug Formulary I. Cost-share, if applicable, does not apply to certain drugs. Visit our website to review our formulary.
Maintenance Medications	2.5 copays for a 3 month supply	2.5 copays for a 3 month supply	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*	Creditable	For those who are Medicare eligible, this plan meets the standard level of prescription drug coverage determined by Medicare.
Vision Services			
Medical Eye Exam	$25 copay / visit	$25 copay / visit	
Routine/ Refractive Exam	$0 copay / visit	$0 copay / visit	Once every 12 months
Standard Plastic Lenses	Single: $50 Bifocal: $70	Single: $50 Bifocal: $70	Contact EyeMed for additional options at 1-877-842-3348
Frames	40% discount	40% discount	Discount is based on retail pricing
Conventional Contact Lenses	15% discount	15% discount	Materials only
Laser Vision Correction	50% discount	50% discount	Up to $400 maximum per eye
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

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.

*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.