Independent Health

Account Name: Buffalo Laborers Welfare Fund
Account #: 31709
Sales Representative: Joel Marinaccio
Plan Effective Date: September 1, 2024

Benefit Summary

Plan Name:	iDirect 1 Series C Style Non-HSA $1500/$3000		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
General Information			
Deductible	$1,500 / $3,000 Combined In and Out-of-Network	$1,500 / $3,000 Combined In and Out-of-Network	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	25%	
Out-of-Pocket Maximum	$5,000 / $10,000	$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	Deductible then 25% 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 $25 copay / visit	Deductible then 25% coinsurance	
Specialist Office Visit	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Allergy Testing & Treatment	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
Outpatient Surgical Procedures (in physician's office)	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
Telemedicine - General Medical Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Behavioral Health Services	$0 copay / consultation	Not Covered	Administered by Teladoc
Telemedicine - Dermatology	Deductible then $40 copay / consultation	Not Covered	Administered by Teladoc

Monthly Premium
Single $675.00
Famly $1,375.00

X:Health & Welfare/IHA-Active/2024 IHA Summary

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Emergency & Urgent Care Services			
Emergency Room	Deductible then $125 copay / visit	Deductible then $125 copay / visit	Copay waived if admitted
Ambulance	Deductible then $25 copay / trip	Deductible then $25 copay / trip	Must be deemed medically necessary
Urgent Care Center	Deductible then $75 copay / visit	Deductible then $75 copay / visit	
Hospital and Other Facility Services			
Inpatient Hospital	Deductible then $250 copay / admission	Deductible then 25% coinsurance	Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year
Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 25% coinsurance	
Inpatient Hospice	Deductible then $0 copay / admission	Deductible then 25% coinsurance	
Outpatient Surgical Procedures (Hospital Facility)	Deductible then $150 copay / visit	Deductible then 25% coinsurance	
Outpatient Surgical Procedures (Ambulatory Surgery Center)	Deductible then $125 copay / visit	Deductible then 25% coinsurance	
Outpatient Surgical Procedures: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 25% coinsurance	
Skilled Nursing Facility	Deductible then $250 copay / admission	Deductible then 25% coinsurance	Up to 45 days per contract year Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year
Diagnostic Testing Services			
Laboratory Testing	Deductible then $0 copay / visit	Deductible then 25% coinsurance	
EKG	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
Routine Radiology	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Advanced Radiology	Deductible then $75 copay / visit	Deductible then 25% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. Annual maximum copay of $750 after deductible is met.
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$0 copay / visit	Deductible then 25% coinsurance	No charge after the initial diagnosis
Inpatient Maternity	Delivery: Deductible then $250 copay / admission Physician: Deductible then $0 copay / procedure	Deductible then 25% coinsurance	Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year

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Plan Name:	iDirect 1 Series C Style Non-HSA $1500/$3000		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Mental Health & Substance Abuse			
Inpatient Mental Health	Deductible then $250 copay / admission	Deductible then 25% coinsurance	Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year
Outpatient Mental Health	Deductible then $25 copay / visit	Deductible then 25% coinsurance	
Inpatient Substance Abuse - Rehab	Deductible then $250 copay / admission	Deductible then 25% coinsurance	Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year
Inpatient Substance Abuse - Detox	Deductible then $250 copay / admission	Deductible then 25% coinsurance	Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year
Outpatient Substance Abuse	Deductible then $25 copay / visit	Deductible then 25% coinsurance	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$0 copay	Deductible then 25% coinsurance	
Insulin and Other Oral Agents	$15 copay	Deductible then 25% coinsurance	Office visit liability or pharmacy rider liability (if applicable), whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	$0 copay	Deductible then 25% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then $15 copay / visit	Deductible then 25% coinsurance	Up to 20 visits per contract year combined
Cardiac Rehabilitation	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Pulmonary Rehabilitation	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
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	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Home Health Care	Deductible then $40 copay / visit	Deductible then 25% coinsurance	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.	Not Covered	

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Benefit Summary

Plan Name:	iDirect 1 Series C Style Non-HSA $1500/$3000		
Benefits	**In-Network**	**Out-of-Network**	**Additional Information**
Prescription Drug Coverage			
Prescription Plan	$10/$20/$35	Not Covered	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	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.
Vision Services			
Medical Eye Exam	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Routine/ Refractive Exam	$0 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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Benefit Summary

Plan Name:	iDirect 1 Series C Style Non-HSA $1500/$3000

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.

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Deductible	$1,500 / $3,000 Combined In and Out-of-Network	$1,500 / $3,000 Combined In and Out-of-Network	Where a deductible applies it accumulates as non-embedded. *See Important Notes section for more detail.
Coinsurance	Applies Where Indicated	25%	
Out-of-Pocket Maximum	$5,000 / $10,000	$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	Deductible then 25% 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 $25 copay / visit	Deductible then 25% coinsurance	
Specialist Office Visit	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Allergy Testing & Treatment	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
Outpatient Surgical Procedures (in physician's office)	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
Telemedicine - General Medical Services	$0 copay / consultation	Not Covered	Administered by Teladoc
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Hospital and Other Facility Services			
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Inpatient Hospital: Physician/Surgeon Fees	Deductible then $0 copay / visit	Deductible then 25% coinsurance	
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Laboratory Testing	Deductible then $0 copay / visit	Deductible then 25% coinsurance	
EKG	Deductible then $25/$40 copay / visit	Deductible then 25% coinsurance	
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Diabetic Equipment (e.g. Blood glucose monitor, etc.)	$0 copay	Deductible then 25% coinsurance	
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Chiropractic Services	Deductible then $40 copay / visit	Deductible then 25% coinsurance	
Physical - Occupational - Speech Therapies	Deductible then $15 copay / visit	Deductible then 25% coinsurance	Up to 20 visits per contract year combined
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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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