Independent Health's

Small Group Benefit Options

IN-NETWORK	Encompass Plus D3	FlexFit Select		Easy Access Opt # 10	Passport Plan Select Opt # 10
BENEFIT HIGHLIGHTS	***$25/$40***	***Active***	***Family***	***$30***	***$25/$40 & Coinsurance Plan***
Primary Care Office Visit	$25 Copay	Adult: $15 Child: $45	Adult: $25 Child: $0	Deductible then $30 Copay	$25 Copay
Specialist Office Visit	$40 Copay	$45 Copay	Adult: $45 Child: $45	Deductible then $30 Copay	$40 Copay
Inpatient Hospital	$500 Copay	$250 Copay	Adult: $250 Child: $0	Deductible then $750 Copay	Deductible then 25% Coinsurance
Outpatient Surgery (Facility)	$150 Copay	$200 Copay	$200 Copay	Deductible then $150 Copay	Deductible then 25% Coinsurance
Routine Radiology	$20 Copay	$45 Copay	$45 Copay	Deductible then $40 Copay	Deductible then 25% Coinsurance
Advanced Radiology	$75 Copay	$150 Copay	$150 Copay	Deductible then $150 Copay	Deductible then 25% Coinsurance
Lab Services	Covered in full	Covered in full	Covered in full	Deductible then $0	Covered in full
Chiropractic Services	$40 Copay	$45 Copay	$45 Copay	Deductible then $30 Copay	Deductible then 25% Coinsurance
Allergy Testing	$25 PCP/$40 Specialist	Adult: $15/$45 Child: $45	Adult: $25/$45 Child: $0/$45	Deductible then $30 Copay	Primary $25 Specialist $40
Durable Medical Equipment ($1,000 max per contract year)	50% Copay	50% Copay	50% Copay	50% Copay after deductible	Deductible then 50% Coinsurance
Mental Health Outpatient (Visit limits may apply based on diagnosis)	$25 Copay	Adult: $15 Child: $25	Adult: $25 Child: $0	50% Copay after deductible	Deductible then 25% Coinsurance
Prosthetics/Appliances	50% Copay	50% Copay	50% Copay	50% Copay after deductible	Deductible then 50% Coinsurance
Laser Vision Correction	15% discount	50% discount up to $300 max	50% discount up to $300 max	15% discount	15% discount
Eyewear Benefits	Copays and Discounts	Copays and Discounts	Copays and Discounts	Copays and Discounts	Copays and Discounts
After Hours Care Center	$75 Copay	$75 Copay	$75 Copay	Deductible then $75 Copay	$75 Copay
Emergency Room	$150 Copay	$200 Copay	$200 Copay	Deductible then $125 Copay	Deductible then $100 Copay
Ambulance	$100 Copay	$200 Copay	$200 Copay	Deductible then $125 Copay	Deductible then $100 Copay
Eye Exam (routine/refractive)	$20 Copay	$10 Copay	$10 Copay	$15 Copay	$20 Copay
Special Benefits	N/A	$250 allowance per subscriber per contract year for a membership to a participating fitness club as well as complimentary alternative therapies to include acupuncture, massage therapy, dietary counseling, yoga, pilates, tai chi and vitamins and herbs	$250 allowance per subscriber per contract year for activities provided at family oriented fitness centers and other organizations. Can be used on fees associated with sports and fitness programs for children, school activity programs and day camp	N/A	N/A
In-Network					
Deductible	N/A	N/A	N/A	$750/$1,500	$500/$1,000
Coinsurance	N/A	N/A	N/A	Not Applicable	25%
Out-of-Pocket Max	N/A	N/A	N/A	$2,250/$4,500	$5,000/$10,000 combined in and out-of-network
Maximum Annual Benefit	N/A	N/A	N/A	N/A	N/A
Maximum Lifetime Benefit	N/A	N/A	N/A	N/A	N/A
Out-of-Network					
Deductible	$500/$1,000	$1,500/$3,000	$1,500/$3,000	N/A	$2,000/$4,000
Coinsurance	25%	30%	30%	N/A	40%
Out-of-Pocket Max	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	N/A	$5,000/$10,000 combined in and out-of-network
Maximum Annual Benefit	Unlimited	Unlimited	Unlimited	N/A	N/A
Maximum Lifetime Benefit	N/A	N/A	N/A	N/A	N/A
Prescriptions (Rx)	$10/$50/$100	$10/$50/$100	$10/$50/$100	$10/$50/$100	$10/$50/$100
Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives
Dependent Coverage	Up to age 26	Up to age 26	Up to age 26	Up to age 26	Up to age 26

This summary is designed to highlight the benefits of the plans 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 Group Health Contract, attached Riders (if any), or Certificate of Coverage.
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Small Group Benefit Options

IN-NETWORK	IDirect 1	IDirect 2	IDirect 4
BENEFIT HIGHLIGHTS	**(C Series) HSA $1500/$3000**	**Non-HSA $1000/$2000**	**HSA $1500/$3000 Coinsurance Plan**
Primary Care Office Visit	Deductible then $20 Copay	Deductible then $15 Copay	Deductible then 10%
Specialist Office Visit	Deductible then $20 Copay	Deductible then $40 Copay	Deductible then 10%
Inpatient Hospital	Deductible then $250	Deductible then 20%	Deductible then 10%
Outpatient Surgery (Facility)	Deductible then $150	Deductible then 20%	Deductible then 10%
Routine Radiology	Deductible then $20	Deductible then 20%	Deductible then 10%
Advanced Radiology	Deductible then $75	Deductible then 20%	Deductible then 10%
Lab Services	Covered in full	Covered in full	Deductible then 10%
Chiropractic Services	Deductible then $20	Deductible then 20%	Deductible then 10%
Allergy Testing	Deductible then $20	Deductible then $15/$40 Copay	Deductible then 10%
Durable Medical Equipment($1,000 max per contract year)	Deductible then 50%	Deductible then 50%	Deductible then 10%
Mental Health Outpatient (Visit limits may apply based on diagnosis)	Deductible then $20	Deductible then 20%	Deductible then 10%
Prosthetics/Appliances	Deductible then 50%	Deductible then 50%	Deductible then 10%
Laser Vision Correction	15% discount	Not covered	15% discount
Eyewear Benefits	Copays & Discounts	Not Covered (Rider Available)	Copays & Discounts
After Hours Care Center	Deductible then $75	Deductible then $75	Deductible then 10%
Emergency Room	Deductible then $125	Deductible then 20%	Deductible then 10%
Ambulance	Deductible then $25	Deductible then 20%	Deductible then 10%
Eye Exam (routine/refractive)	$10 Copay	Not Covered (Rider Available)	$10
In-Network			
Deductible	$1,500 Single/$3,000 Family (Combined in and out-of-network)	$1,000 Single/$2,000 Family (Combined in and out-of-network)	$1,500 Single/$3,000 Family (Combined in and out-of-network)
Coinsurance	N/A	20%	10%
Out-of-Pocket Max	$5,000 Single/$10,000 Family	$5,000 Single/$10,000 Family	$5,000 Single/$10,000 Family
Maximum Annual Benefit	N/A	N/A	N/A
Maximum Lifetime Benefit	N/A	N/A	N/A
Out-of-Network			
Deductible	$1,500 Single/$3,000 Family (Combined in and out-of-network)	$1,000 Single/$2,000 Family (Combined in and out-of-network)	$1,500 Single/$3,000 Family (Combined in and out-of-network)
Coinsurance	25%	40%	30%
Out-of-Pocket Max	$10,000 Single/$20,000 Family	$10,000 Single/$20,000 Family	$10,000 Single/$20,000 Family
Maximum Annual Benefit	N/A	N/A	N/A
Maximum Lifetime Benefit	N/A	N/A	N/A
Prescriptions (Rx)	Deductible then $10/$50/$100	$10/$50/$100	Deductible then $10/$50/$100
Oral Contraceptives	Deductible and $0 Copay for Tier 1 Oral Contraceptives	$0 Copay for Tier 1 Oral Contraceptives	Deductible and $0 Copay for Tier 1 Oral Contraceptives
Dependent Coverage	Up to age 26	Up to age 26	Up to age 26

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