Independent Health
SELF-FUNDED SERVICES

Group Name: Gernatt Asphalt

Benefit Summary

	HDHP Plan 2 2023		
	In-Network	**Out-of-Network**	**Additional Information**
Preventive Services			
Abdominal aortic aneurysm screen Bacteria Screening, Urine (pregnant woman 12-16 weeks) Basic metabolism test (general health panel) Bone mineral density measurements or tests Chlamydia screening Cholesterol test (lipid panel) Colonoscopy and sigmoidoscopy Fecal blood testing Gonorrhea Screening Hemoglobin and hematocrit testing HIV screening HPV screening Immunizations Lead screen in childhood and/or pregnancy Mammogram Pap smear Physical exam Prenatal and one postpartum visit Prostate test (Prostate Specific Antigen "PSA") Rh screen Rubella screening Smoking Cessation products/counseling Syphilis Infection Screening Type 2 Diabetes Screening in Adults Well Child Visits	$0 copay	$0 copay	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 20% coinsurance/visit	
Specialist Office Visit	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Allergy Testing& Treatment	PCP: Deductible then $25 copay/visit SCP: Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Outpatient Surgical Procedures (in physician's office)	PCP: Deductible then $25 copay/visit SCP: Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	Pre-certification required
Emergency and Urgent Care Services			
Emergency Room	Deductible then $150 copay/visit	Deductible then $150 copay/visit	Waived if admitted
Ambulance	Deductible then $100 copay/trip	Deductible then $100 copay/trip	Must be deemed medically necessary
Participating After Hours Care Centers	Deductible then $35 copay/visit	Not applicable	
Hospital Services			
Inpatient Hospital	Deductible then $250	Deductible then 20%	Semi-private room per

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	copay/admission	coinsurance/admission	admission Pre-certification required
Inpatient Hospital Physician/Surgeon Fees	Deductible then $0 copay/visit	Deductible then 20% coinsurance	
Inpatient Hospice	Deductible then $0 copay/admission	Deductible then 20% coinsurance/admission	No visit limit. Hospice services shall include both inpatient and outpatient services, as well as medically necessary supplies and drugs.
Outpatient Surgical Procedures (Facility)	Deductible then $150 copay/visit	Deductible then 20% coinsurance/visit	Pre-certification required
Outpatient Surgical Procedures (Facility): Physician/Surgeon Fees	Deductible then $0 copay/visit	Deductible then 20% coinsurance/visit	
Skilled Nursing Facility	Deductible then $250 copay/admission	Deductible then 20% coinsurance/admission	Up to 45 days per contract year. In-network plus out-of-network services combined equal the total benefit. Semi-private room, per admission. Custodial care is not covered. Pre-certification required.
Diagnostic Testing Services			
Laboratory Testing	Deductible then $0 copay/visit	Deductible then 20% coinsurance/visit	
EKG	PCP: Deductible then $25 copay/visit SCP: Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Routine Radiology	PCP: Deductible then $25 copay/visit SCP: Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Advanced Radiology	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	Radiology services, other than x-rays, including but not limited to MRI, MRA, CT Scans, PET Scans.
Maternity Services			
Physician Services: Prenatal and Postnatal Care	$0 copay/visit	Deductible then 20% coinsurance/visit	No charge after the initial diagnosis
Inpatient Maternity	Delivery: Deductible then $250 copay/admission Physician: Deductible then $0 copay/procedure	Deductible then 20% coinsurance	Semi-private room per admission
Mental Health and Substance Abuse			
Inpatient Mental Health	Deductible then $250 copay/admission	Deductible then 20% coinsurance/admission	Semi-private room per admission. Pre-certification required.
Outpatient Mental Health	Deductible then $25 copay/visit	Deductible then 20% coinsurance/visit	

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Inpatient Substance Abuse – Rehab	Deductible then $250 copay/admission	Deductible then 20% coinsurance/admission	Pre-certification required.
Inpatient Substance Abuse – Detox	Deductible then $250 copay/admission	Deductible then 20% coinsurance/admission	Pre-certification required.
Outpatient Substance Abuse	Deductible then $25 copay/visit	Deductible then 20% coinsurance/visit	
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc)	$0 copay	Deductible then 20% coinsurance	Pre-certification required
Insulin and Other Oral Agents	EmpiRx	EmpiRx	
Diabetic Medical Supplies (Test Strips, Syringes, etc)	$0 copay	Deductible then 20% coinsurance	
Rehabilitation Services			
Chiropractic Services	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	Up to 30 visits per contract year. In-network plus out-of-network services combined equal the total benefit.
Physical – Occupational – Speech Therapies	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	Up to 60 visits per contract year, combined. In-network plus out-of-network services combined equal the total benefit.
Cardiac Rehabilitation	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Pulmonary Rehabilitation	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Additional Services			
Durable Medical Equipment (DME)	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Pre-certification required
Prosthetics and Appliances	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Pre-certification required
Chemotherapy	PCP: Deductible then $25 copay/visit SCP: Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Home Health Care	Deductible then $0 copay/visit	Deductible then 20% coinsurance/visit	Up to 40 visits per contract year. In-network plus out-of-network services combined equal the total benefit. Pre-certification required.
Prescription Drug Coverage			

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Prescription Plan	EmpiRx	EmpiRx	
Contraceptive Drugs & Devices	EmpiRx	EmpiRx	
Maintenance Medications	EmpiRx	EmpiRx	
Vision Services			
Medical Eye Exam	Deductible then $40 copay/visit	Deductible then 20% coinsurance/visit	
Routine/ Refractive Exam	$20 copay/ visit	Not covered	
Optical Dispensing	$100 reimbursement for a single person, and up to 3 people on a family plan are allowed that $100 reimbursement each (max $300).	$100 reimbursement for a single person, and up to 3 people on a family plan are allowed that $100 reimbursement each (max $300).	
Dental Services			
Preventive and Routine	Not covered	Not covered	
Accidental Dental	Based on site of service	Based on site of service	Must be deemed medically necessary
Dependent Coverage			
Dependent Eligibility	Up to age 26	Up to age 26	Up to the end of the birthday month

General Information			
Deductible	$3,000 Individual/ $6,000 Family		
Coinsurance	Not Applicable	20%	
Out-of-Pocket Maximum	$5,000 Individual/ $10,000 Family		
Annual & Lifetime Maximum	Not applicable	Not applicable	
Pre-Certification	Certain services and benefits are subject to pre-certification. Member is responsible for contacting Independent Health for pre-certification.		
Pre-Existing Conditions	Not applicable		

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Important Notes

Out-of-Network: Member is responsible for the difference between Independent Health's allowed amount and the non-participating provider's billed amount.

Pre-Certification: Certain services and benefits are subject to pre-certification. Member is responsible for reviewing their Summary Plan Description (SPD) for pre-certification requirements. Penalty for not pre-certifying: the member is responsible for the payment of 50% of the eligible expenses for each service. Additional payments may apply. This additional percentage is a PENALTY and does not apply to the out-of-pocket maximum, deductible, and coinsurance.

This benefit summary is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitation, and exclusions. For more detailed information consult your Summary Plan Description (SPD).

All indicated benefits assume the member has appropriate authorization to receive services.

To locate a participating provider, please visit www.independenthealth.com. It is recommended you call your provider's office to verify participation prior to each visit.