

Group Name: Gernatt Asphalt

HDHP Plan 3 2023

## Benefit Summary

	In-Network	Out-of-Network	Additional Information
<b>Preventive Services</b>			
Abdominal aortic aneurysm screen	\$0 copay	\$0 copay	All preventive services are covered in full with \$0 member liability when performed by a participating provider. See <a href="http://independenthealth.com">independenthealth.com</a> for additional information.
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			
<b>Physician and Other Services</b>			
Primary Office Visit	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Specialist Office Visit	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Allergy Testing & Treatment	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Outpatient Surgical Procedures (in physician's office)	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	Pre-certification required
<b>Emergency and Urgent Care Services</b>			
Emergency Room	Deductible then \$0 copay/visit	Deductible then \$0 copay/visit	Waived if admitted
Ambulance	Deductible then \$0 copay/trip	Deductible then \$0 copay/trip	Must be deemed medically necessary
Participating After Hours Care Centers	Deductible then \$0 copay/visit	Not applicable	
<b>Hospital Services</b>			
Inpatient Hospital	Deductible then \$0 copay/admission	Deductible then 20% coinsurance/admission	Semi-private room per admission Pre-certification required
Inpatient Hospital Physician/Surgeon Fees	Deductible then \$0 copay/visit	Deductible then 20% coinsurance	

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**HDHP Plan 3 2023**

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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 \$0 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 \$0 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.
<b>Diagnostic Testing Services</b>			
Laboratory Testing	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
EKG	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Routine Radiology	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Advanced Radiology	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	Radiology services, other than x-rays, including but not limited to MRI, MRA, CT Scans, PET Scans.
<b>Maternity Services</b>			
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 \$0 copay/admission Physician: Deductible then \$0 copay/procedure	Deductible then 20% coinsurance	Semi-private room per admission
<b>Mental Health and Substance Abuse</b>			
Inpatient Mental Health	Deductible then \$0 copay/admission	Deductible then 20% coinsurance/admission	Semi-private room per admission. Pre-certification required.
Outpatient Mental Health	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
Inpatient Substance Abuse – Rehab	Deductible then \$0 copay/admission	Deductible then 20% coinsurance/admission	Pre-certification required.
Inpatient Substance Abuse – Detox	Deductible then \$0 copay/admission	Deductible then 20% coinsurance/admission	Pre-certification required.
Outpatient Substance Abuse	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	

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HDHP Plan 3 2023

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<b>Diabetic Supplies and Services</b>			
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	
<b>Rehabilitation Services</b>			
Chiropractic Services	Deductible then \$0 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 \$0 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 \$0 copay/visit	Deductible then 20% coinsurance/visit	
Pulmonary Rehabilitation	Deductible then \$0 copay/visit	Deductible then 20% coinsurance/visit	
<b>Additional Services</b>			
Durable Medical Equipment (DME)	Deductible then \$0 copay	Deductible then 20% coinsurance	Pre-certification required
Prosthetics and Appliances	Deductible then \$0 copay	Deductible then 20% coinsurance	Pre-certification required
Chemotherapy	Deductible then \$0 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.
<b>Prescription Drug Coverage</b>			
Prescription Plan	EmpiRx	EmpiRx	
Contraceptive Drugs & Devices	EmpiRx	EmpiRx	
Maintenance Medications	EmpiRx	EmpiRx	
<b>Vision Services</b>			
Medical Eye Exam	Deductible then \$0 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	\$100 reimbursement for a single person, and up to 3	

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**HDHP Plan 3 2023**

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	people on a family plan are allowed that \$100 reimbursement each (max \$300).	people on a family plan are allowed that \$100 reimbursement each (max \$300).	
<b>Dental Services</b>			
Preventive and Routine	Not covered	Not covered	
Accidental Dental	Based on site of service	Based on site of service	Must be deemed medically necessary
<b>Dependent Coverage</b>			
Dependent Eligibility	Up to age 26	Up to age 26	Up to the end of the birthday month

General Information			
Deductible	\$5,000 Individual/ \$10,000 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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## Benefit Summary

**In-Network**

**Out-of-Network**

**Additional Information**

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](http://www.independenthealth.com). It is recommended you call your provider's office to verify participation prior to each visit.