



Account Name: NY Power Authority

Account #: 22637

Plan Effective Date: January 1, 20 21

Benefit Summary

Pending NYS Department of
Financial Services Approval

Plan Name:	FlexFit		
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	In-Network: Not Applicable Out-of-Network: Unlimited	In-Network: Not Applicable Out-of-Network: Unlimited	
Preventive Services			
Bone mineral density measurements or tests Cholesterol test (lipid panel) Colonoscopy and Sigmoidoscopy Contraceptive Drugs, Devices and Counseling Immunizations Mammogram Pap smear Physical exam Prenatal and 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	Adults: \$10 copay / visit Children: \$25 copay / visit	Adults: \$15 copay / visit Children: \$0 copay / visit	PCP Required
Specialist Office Visit	Adults: \$25 copay / visit Children: \$25 copay / visit	Adults: \$25 copay / visit Children: \$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)	Adults: \$10/\$25 copay / visit Children: \$25 copay / visit	Adults: \$15/\$25 copay / visit Children: \$0/\$25 copay / visit	
Telemedicine General Medicine	Adults: \$10 consultation Children: \$25 consultation	Adults: \$15 consultation Children: \$0 consultation	
Telemedicine Behavioral Health	Adults: \$10 consultation Children: \$0 consultation	Adults: \$15 consultation Children: \$0 consultation	
Telemedicine Dermatology	Adults: \$25 consultation Children: \$25 consultation	Adults: \$25 consultation Children: \$25 consultation	
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	



Account Name: NY Power Authority

Account #: 22637

Plan Effective Date: January 1, 2021

Benefit Summary

Pending NYS Department of
Financial Services Approval

Plan Name:	FlexFit		
Benefits	Active	Family	Additional Information
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	\$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
Inpatient Maternity	Delivery: \$0 copay / admission Physician: \$0 copay / procedure	Delivery: \$0 copay / admission Physician: \$0 copay / procedure	Semi-private room, per admission
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	



Account Name: NY Power Authority

Account #: 22637

Plan Effective Date: January 1, 20 21

Benefit Summary

Pending NYS Department of
Financial Services Approval

Plan Name:	FlexFit		
Benefits	Active	Family	Additional Information
Diabetic Supplies and Services			
Diabetic Equipment (e.g. Blood glucose monitor, etc.)	\$10 copay	\$15 copay	
Insulin and Other Oral Agents	\$10 copay	\$15 copay	Office visit copay or pharmacy rider copay, whichever is less
Diabetic Medical Supplies (Test Strips, Syringes, etc.)	\$10 copay	\$15 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
Cardiac Rehabilitation	\$25 copay / visit	\$25 copay / visit	Up to 36 visits per event
Pulmonary Rehabilitation	\$25 copay / visit	\$25 copay / visit	Up to 24 visits per contract year
Additional Services			
Durable Medical Equipment	20% coinsurance	20% coinsurance	
Prosthetics and Appliances	20% coinsurance	20% coinsurance	
Chemotherapy	Adults: \$10/\$25 copay / visit Children: \$25 copay / visit	Adults: \$15/\$25 copay / visit Children: \$0/\$25 copay / visit	
Home Health Care	\$25 copay / visit	\$25 copay / visit	Up to 40 visits per contract year
Unique Benefits	\$250 allowance	\$250 allowance	To be used to pay for eligible health & wellness activities at participating Health Extras vendors
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.
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, therefore this plan provides you with CREDITABLE COVERAGE



Account Name: NY Power Authority

Account #: 22637

Plan Effective Date: January 1, 20 21

Benefit Summary

Pending NYS Department of
Financial Services Approval

Plan Name:	FlexFit		
Benefits	Active	Family	Additional Information
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
Important Notes			
<p>Deductible is determined as of the date(s) claims are processed by Independent Health, not the date services were rendered.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Member Pre-Authorization: Certain services and benefits are subject to member pre-authorization. Member is responsible for contacting Independent Health for pre-authorization.</p> <p>Child (if applicable): Cost-share applies if member is under the age of 19.</p> <p>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.</p> <p>All indicated benefits assume the member has appropriate authorization to receive services.</p> <p>Certain benefits stated in this benefit summary may be pending NYS approval.</p>			

Nondiscrimination statement and language assistance services

If you, or someone you're helping, have questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

如果您，或是您正在協助的對象，有關於[插入 Independent Health 項目的名稱 Independent Health 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-501-3439]。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Independent Health 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-501-3439 로 전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

אויב איר, אודר עמזעער איר העלפסט, האט פראגעס וועגן Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע אין אייער שפראך אומזיסט. צו רעדן מיט דער איבערזעצער, קלונג 1-800-501-3439

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3439

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-800-501-3439

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال ہے Independent Health کے بارے میں، تو آپ دونوں کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 1-800-501-3439 فون کریں۔

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-501-3439.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>