Employer Services Corporation
Independent Health
2017-2018 WNY Medical Options: May 1, 2017 - April 30, 2018

Description	FlexFit Select Copay		Passport Plan Select Option 10 Hybrid	iDirect 1 Series C 1500 High Deductible	iDirect 2 Series 2500 High Deductible	iDirect 5 Series 6350 High Deductible Value
	A copay plan.		A hybrid plan option that combines copays with a small deductible and some coinsurance. Office visits and prescriptions are not subject to the deductible.	A high-deductible plan with copays.	A high-deductible plan with copays and coinsurance	A high deductible plan with coinsurance minimum value plan
	ACTIVE	FAMILY				
Deductible	N/A	N/A	$500/$1,000 (Embedded)[1]	$1,500/$3,000 (True-Family)[2]	$2,500/$5,000 (True-Family)[2]	$6,350/$12,700 (Embedded)[1]
Co-Insurance	Applied Where Indicated	Applied Where Indicated	25%	Applies Where Indicated	20%	Applies Where Indicated
In-Network Out-of-Pocket Max	$6,350/$12,700 (Embedded)[1]	$6,350/$12,700 (Embedded)[1]	$5,000/$10,000 (Embedded)[1]	$5,000/$10,000 (Embedded)[1]	$5,000/$10,000 (Embedded)[1]	$6,350/$12,700 (Embedded)[1]
Basic						
Office Co-pay	Adult: $30 Child: $30	Adult: $30 Child: $0	$25	Deductible then $25	Deductible then $25	Deductible then covered in full
Specialist Co-Pay	$50	$50	$40	Deductible then $40	Deductible then $25	Deductible then covered in full
Office Visit for dependents under age 19	$30	$0/$50	$25/$40	Deductible then $25/$40	Deductible then $25	Deductible then covered in full
Well Child Visits and Immunizations for dependents under age 19	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Maternity-Pre/Post Care	Covered in Full (after copay for initial visit)	Covered in Full (after copay for initial visit)	Covered in Full (after copay for initial visit)	Covered in Full (after deductible and copay for initial visit)	Covered in Full (after deductible and coinsurance for initial visit)	Covered in Full (after deductible and copay for initial visit)
Telemedicine	$10 per call	$10 per call	$10	Deductible then $10	Deductible then $10	Deductible then covered in full
Routine Radiology	$45	$45	Deductible then 25%	Deductible then $40	Deductible then 20%	Deductible then covered in full
Lab & Pathology	Covered in Full	Covered in Full	Covered in Full	Deductible then covered in full	Deductible then covered in full	Deductible then covered in full
Advanced Radiology	$100	$100	Deductible then 25%	Deductible then $75	Deductible then 20%	Deductible then covered in full
Chiropractic	$50	$50	Deductible then 25%	Deductible then $40	Deductible then 20%	Deductible then covered in full
Allergy	Adult: $30/$50 Child: $30/$50	Adult: $30/$50 Child: $0/$50	$25/$40	Deductible then $25/$40	Deductible then $25	Deductible then covered in full
Prescription						
Tier 1st / 2nd / 3rd	$10/$30/$100	$10/$30/$100	$10/$50/$100	Deductible then $10/$50/$100	Deductible then $10/$30/$100	Deductible then covered in full
Routine/Preventative						
	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Hospitalization						
Hospital Stay (semi-private room)	$1,000 Per Admission	Adult: $1,000 Child:$0	Deductible then 25%	Deductible then $500 Per Admission	Deductible then 20%	Deductible then covered in full
Emergency Services (waived if admitted)	$250 Per Visit	$250 Per Visit	Deductible then $100 Per Visit	Deductibe then $125 Per Visit	Deductible then 20%	Deductible then covered in full
Ambulance	$200 Per Trip	$200 Per Trip	Deductible then $100 Per Trip	Deductibe then $25 Per Trip	Deductible then 20%	Deductible then covered in full
Urgent Care	$75 Per Visit	$75 Per Visit	$75 Per Visit	Deductible then $75 Per Visit	Deductible then $75	Deductible then covered in full
Maternity-Hospital	$1,000	$0	Deductible then 25%	Deductible then $500 Per Admission	Deductible then 20%	Deductible then covered in full
Maternity-Physician	Covered in full	Covered in full	Deductible then 25%	Deductible the covered in full	Deductible then 20%	Deductible then covered in full
Outpatient Surgery	$250	$250	Deductible then 25%	Deductible then $150	Deductible then 20%	Deductible then covered in full
Other Services						
Domestic Partner Rider	Covered with Children	Covered with Children	Covered with Children	Covered with Children	Covered with Children	Covered with Children
Vision	Medical eye exam $50 copay; Routine Exam $10 copay	Medical eye exam $50 copay; Routine Exam $10 copay	Medical eye exam Deductible then 25% coninsurance; Routine Exam $20 copay	Medical eye exam Deductible then $25/$40 copay; Routine exam $10 copay	Medical eye exam Deductible then 20% coninsurance; Routine exam $10 copay	Medical eye exam Deductible then $0; Routine exam $10 copay
Dependent/Student Age	26 / 26	26 / 26	26 / 26	26 / 26	26 / 26	26 / 26
HSA Eligible	No	No	No	Yes	Yes	Yes
Unique Benefit	$250 Wellness Card (Health Extras)	$250 Wellness Card (Health Extras)	$250 Wellness Card (Health Extras)	$250 Wellness Card (Health Extras)	$250 Wellness Card (Health Extras)	$250 Wellness Card (Health Extras)
Out of Network						
Out of Network Deductible	$1,500/$3,000 (Embedded)[1]	$1,500/$3,000	$2,000/$4,000 (Embedded)[1]	$1,500/$3,000 (True-Family)[2]	$2,500/$5,000 (True-Family)[2]	Not Covered
Out of Network Co-Insurance	30%	30%	40%	25%	40%	Not Covered
Out-of-Network Out-of-Pocket Max	$10,000/$20,000 (Embedded)[1]	$10,000/$20,000 (Embedded)[1]	$5,000/$10,000 (Embedded)[1]	$10,000/$20,000 (Embedded)[1]	$10,000/$20,000 (Embedded)[1]	Not Covered

***a monthly fee may apply to H.S.A. accounts**

****Summary of Benefits and Coverage (SBC) are available upon request**

*****Exchange Notices are available upon request (Health Insurance Marketplace)**

1-Embedded: Your plan tracks dollars spent on medical services at both Individual and Family levels. By tracking spending levels at the Individual level, each member of your family has the opportunity to meet their own deductible – having insurance coverage begin (e.g., copay,coinsurance) prior to the entire dollar amount of the family deductible being met.

2-True-Family: Your plan tracks dollars spent on medical services at the Family level. This means that the entire dollar amount of the family deductible must be met before coverage (e.g., copay, coinsurance) begins.

Eligibility is based on Participation Requirements. This is not a complete comparison or contract and should be understood as only a guide to assist you. Please refer to your plan document for a complete benefit detail.

Employer Services Corporation

20 Pineview Drive ● Amherst ● New York 14228 ● 716 691 4455 ● 716 691 4234 ● www.myesc.com ● info@myesc.com