



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.independenthealth.com or by calling 1-800-501-3439.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	In-Network: \$750 Single/ \$1500 Family Out-of-Network: \$2500 Single/ \$5000 Family	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1 st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. In-Network: \$6350 Single/ \$12,700 Family Out-of-Network: \$10,000 Single / \$20,000 Family	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, balance-billed charges, penalty amounts, and non-covered services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.independenthealth.com or call 1-800-501-3439 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without the permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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If you aren't clear about any of the bolded terms used in this form, see the Glossary.

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **In-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15 copay/visit	40% coinsurance	Not subject to deductible
	Specialist visit	\$45 copay/visit	40% coinsurance	Not subject to deductible
	Other practitioner office visit	Chiropractor: \$45 copay/visit Allergy injections: \$15/\$45 copay/visit	40% coinsurance	Not subject to deductible
	Preventive care/screening/immunization	No charge	40% coinsurance	All preventive services are covered in full with \$0 member liability when performed by a participating provider. See independenthealth.com for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$45 copay/visit Blood work: \$25 copay/visit EKG: \$45 copay/visit	40% coinsurance	---None---

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	Imaging (CT/PET scans, MRIs)	\$100 copay/visit	40% coinsurance	Radiology services, other than x-rays; including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. Authorization may be required
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at independenthealth.com .	Prescription Drugs Tier 1	\$4 copay/prescription	Not covered	Not subject to deductible Must be filled at a participating pharmacy
	Prescription Drugs Tier 2	\$30 copay/prescription	Not covered	Not subject to deductible Must be filled at a participating pharmacy
	Prescription Drugs Tier 3	50% coinsurance	Not covered	Not subject to deductible Must be filled at a participating pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay/visit	40% coinsurance	Authorization may be required
	Physician/surgeon fees	\$45 copay/visit	40% coinsurance	Authorization may be required
If you need immediate medical attention	Emergency room services	\$150 copay/visit	\$150 copay/visit	Not subject to deductible
	Emergency medical transportation	\$150 copay/trip	\$150 copay/trip	Not subject to deductible Must be deemed medically necessary
	Urgent care	\$75 copay/visit	\$75 copay/visit	Not subject to deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 copay/admission	40% coinsurance	Semi-private room, per admission Authorization may be required
	Physician/surgeon fee	No charge	40% coinsurance	Authorization may be required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$45 copay/visit	40% coinsurance	Not subject to deductible
	Mental/Behavioral health inpatient services	\$1,000 copay/admission	40% coinsurance	Semi-private room, per admission Authorization may be required
	Substance use disorder outpatient services	\$45 copay/visit	40% coinsurance	Not subject to deductible
	Substance use disorder inpatient services	\$1,000 copay/admission	40% coinsurance	Semi-private room, per admission Authorization may be required
If you are pregnant	Prenatal and postnatal care	No charge	40% coinsurance	No charge after the initial diagnosis

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	Delivery and all inpatient services	Delivery: \$1,000 copay/admission Physician: No charge	40% coinsurance	Semi-private room, per admission
If you need help recovering or have other special health needs	Home health care	\$15 copay/visit	40% coinsurance	Up to 40 visits per contract year Authorization may be required
	Rehabilitation services	\$45 copay/visit	40% coinsurance	Up to 60 visits per condition per plan year
	Habilitation services	\$45 copay/visit	40% coinsurance	Up to 60 visits per condition per plan year
	Skilled nursing care	\$1,000 copay/admission	40% coinsurance	Semi-private room Authorization may be required
	Durable medical equipment	50% coinsurance	50% coinsurance	Authorization may be required
	Hospice service	Inpatient: No charge Outpatient: No charge	40% coinsurance	Up to 210 days combined inpatient/outpatient per contract year
If your child needs dental or eye care	Eye exam	\$20 copay/visit	Not covered	One routine exam every calendar year
	Glasses	30% coinsurance	Not covered	---None---
	Dental check-up	Not covered	Not covered	---None---

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult)

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Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-501-3439. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact our Member Services Department at (716) 631-8701 or 1-800-501-3439 from 8:00am to 8:00pm, Monday through Friday. TDD users, please call (716) 631-3108.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$5,630**
- **Patient pays \$1,910**

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$750
Co-pays	\$1,010
Co-insurance	\$0
Limits or exclusions	\$150
Total	\$1,910

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers: \$5,400**
- **Plan pays \$3,920**
- **Patient pays \$1,480**

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$750
Co-pays	\$650
Co-insurance	\$0
Limits or exclusions	\$80
Total	\$1,480

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Nondiscrimination statement and language assistance services

English

If you, or someone you're helping, has 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.

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.

Spanish

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.

Independent Health cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Chinese

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]。

Independent Health 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Russian

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.

Independent Health соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

French Creole

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.

Nondiscrimination statement and language assistance services (cont'd)

Independent Health konfòm ak lwa sou dwa sivil Federal ki aplikab yo e li pa fè diskriminasyon sou baz ras, koulè, peyi orijin, laj, enfimite oswa sèks.

Korean

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.

Independent Health은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Italian

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.

Independent Health è conforme a tutte le leggi federali vigenti in materia di diritti civili e non pone in essere discriminazioni sulla base di razza, colore, origine nazionale, età, disabilità o sesso.

Yiddish

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

Independent Health קומט נאך פעדעראלע ציווילע רעכטן געזעצן און דיסקרימינירט נישט אויפן באזיס פון ראסע, קאליר, נאציאנאלע אפשטאם, דיסאביליטי, אדער געשלעכט.

Bangala-Bangali

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.

Independent Health প্রয়োজ্য ফেডারেল নাগরিক অধিকার আইন মেনে চলে এবং জাতি, রঙ, জাতীয় উৎপত্তি, বয়স, অক্ষমতা, বা লিঙ্গের ভিত্তিতে বৈষম্য করে না।

Nondiscrimination statement and language assistance services (cont'd)

Polish

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.

Independent Health postępuje zgodnie z obowiązującymi federalnymi prawami obywatelskimi i nie dopuszcza się dyskryminacji ze względu na rasę, kolor skóry, pochodzenie, wiek, niepełnosprawność bądź płeć.

Arabic

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

يلتزم Independent Health بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

French

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.

Independent Health respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Urdu

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۔

Independent Health قابل اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Nondiscrimination statement and language assistance services (cont'd)

Tagalog

Kung ikaw, o ang iyong tinutulangan, 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 angisang tagasalin, tumawag sa 1-800-501-3439.

Sumusunod ang Independent Health sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Greek

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.

Independent Health συμμορφώνεται με τους ισχύοντες ομοσπονδιακούς νόμους για τα ατομικά δικαιώματα και δεν προβαίνει σε διακρίσεις με βάση τη φυλή, το χρώμα, την εθνική καταγωγή, την ηλικία, την αναπηρία ή το φύλο.

Albanian

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.

Independent Health vepron në përputhje me ligjet e zbatueshme federale të të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia.

Nondiscrimination statement and language assistance services (cont'd)

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)

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