

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a **summary**. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-501-3439 or visit www.independenthealth.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.independenthealth.com or call 1-800-501-3439 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | In-network: Individual and Family \$0 Out-of-network: \$5,000 Individual / \$10,000 Family | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | For network providers \$5,250 Individual / \$10,500 Family; for out-of-network providers \$10,000 Individual / \$20,000 Family. | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| 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 . |
| Will you pay less if you use a network provider ? | Yes. See www.independenthealth.com or call 1-800-501-3439 for a list of network providers . | This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist ? | No. | You can see the specialist you choose without a referral . |



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|------------------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$10 copay / visit | 50% coinsurance | PCP Required Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Specialist visit | \$40 copay / visit | 50% coinsurance | ---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Preventive care/screening /immunization | No charge | 50% coinsurance | You may have to pay for services that aren't preventive. Ask your provider if the services are preventive. Then check what your plan will pay for. Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-ray: \$40 copay / visit; Blood work: \$10 copay / visit; EKG: \$10/\$40 copay / visit | 50% coinsurance | ---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Imaging (CT/PET scans, MRIs) | \$85 copay / visit | 50% coinsurance | Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com | Preferred Generic Drugs (Tier 1) | \$5 | Not Covered | If this plan provides prescription drug coverage, deductible does not apply. Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. |
| | Non-Preferred Generic Drugs (Tier 2) | \$30 | Not Covered | If this plan provides prescription drug coverage, deductible does not apply. Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. |
| | Non-Preferred Brand Name Drugs (Tier 3) | 50% | Not Covered | If this plan provides prescription drug coverage, deductible does not apply. Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$75 copay / visit | 50% coinsurance | Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Physician/surgeon fees | \$0 copay / visit | 50% coinsurance | Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| If you need immediate medical attention | Emergency room care | \$150 copay / visit | \$150 copay / visit | Copay waived if admitted |
| | Emergency medical transportation | \$150 copay / trip | \$150 copay / trip | Must be deemed medically necessary |
| | Urgent care | \$75 copay / visit | \$75 copay / visit | ---None--- |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$500 <u>copay</u> / admission | 50% <u>coinsurance</u> | Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Physician/surgeon fees | \$0 <u>copay</u> / visit | 50% <u>coinsurance</u> | ---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$10 <u>copay</u> / visit | 50% <u>coinsurance</u> | ---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Inpatient services | \$500 <u>copay</u> / admission | 50% <u>coinsurance</u> | Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| If you are pregnant | Office visits | \$0 <u>copay</u> / visit | 50% <u>coinsurance</u> | No charge after the initial diagnosis |
| | Childbirth/delivery professional services | Physician: \$0 <u>copay</u> / procedure | 50% <u>coinsurance</u> | Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Childbirth/delivery facility services | Delivery: \$500 <u>copay</u> / admission | 50% <u>coinsurance</u> | Semi-private room, per admission |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | \$40 <u>copay</u> / visit | 50% <u>coinsurance</u> | Up to 40 visits per <u>plan</u> year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Rehabilitation services | \$40 <u>copay</u> / visit | 50% <u>coinsurance</u> | Up to 60 visits per condition per <u>plan</u> year |
| | Habilitation services | \$40 <u>copay</u> / visit | 50% <u>coinsurance</u> | ---None--- |
| | Skilled nursing care | \$500 <u>copay</u> / admission | 50% <u>coinsurance</u> | Semi-private room, per admission Unlimited days per <u>plan</u> year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Durable medical equipment | 50% <u>coinsurance</u> | 50% <u>coinsurance</u> | Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance. |
| | Hospice services | \$0 <u>copay</u> / admission | 50% <u>coinsurance</u> | Up to 210 days per <u>plan</u> year |
| If your child needs dental or eye care | Children's eye exam | \$20 <u>copay</u> / visit | Not Covered | Once every 12 months |
| | Children's glasses | 30% <u>coinsurance</u> | Not Covered | Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348 |
| | Children's dental check-up | Not Covered | Not Covered | ---None--- |

Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|----------------------------|
| • Acupuncture | • Long-Term Care | • Routine Eye Care (Adult) |
| • Cosmetic Surgery | • Non-Emergency Care When Traveling Outside the U.S. | • Routine Foot Care |
| • Dental Care (Adult) | • Private-Duty Nursing | • Weight Loss Programs |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------|-------------------------|
| • Bariatric Surgery | • Hearing Aids | • Infertility Treatment |
| • Chiropractic Care | | |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your [appeal](#). Contact: Community Service Society of New York at 1-888-614-5400 or <http://www.communityhealthadvocates.org/>.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Please refer to Nondiscrimination statement and language assistance services contained within.

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

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

| Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery) | Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | Mia's Simple Fracture (in-network emergency room visit and follow up care) |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|

| | | | | | |
|------------------------------------------------------------------------|--------------|------------------------------------------------------------------------|--------------|------------------------------------------------------------------------|--------------|
| ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 | ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$40 | ■ Specialist copayment | \$40 | ■ Specialist copayment | \$40 |
| ■ Hospital (facility) copayment | \$500 | ■ Hospital (facility) copayment | \$500 | ■ Hospital (facility) copayment | \$500 |
| ■ Other copayment | \$40 | ■ Other copayment | \$40 | ■ Other copayment | \$40 |

This EXAMPLE event includes services like:
 Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

This EXAMPLE event includes services like:
 Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

This EXAMPLE event includes services like:
 Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

| | | | | | |
|---------------------------|----------------|---------------------------|---------------|---------------------------|---------------|
| Total Example Cost | \$12700 | Total Example Cost | \$7400 | Total Example Cost | \$1900 |
|---------------------------|----------------|---------------------------|---------------|---------------------------|---------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|---------------|
| Deductibles | \$0 |
| Copayments | \$1100 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1160 |

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$760 |

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$20 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$520 |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Independent Health Member Services at 1-800-501-3439.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

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 עמבער איר העלפטט, האט פראגעס וועגן, Independent Health, האט דאס רעכט צו באקומען הילף און אינפארמאציע און איינער 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 অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং ভাষা জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন 1-800-501-3739

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 تساعدك 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

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 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.

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>