



 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](http://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](http://www.independenthealth.com) or call 1-800-501-3439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	In-network: \$500 Individual / \$1,000 Family Out-of-network: Not covered	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this plan covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	Medical: \$3,000/\$6,000 Prescription Drugs: \$1,500/\$3,000	Not Covered
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billed charges, penalty amounts, and non-covered services.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.independenthealth.com">www.independenthealth.com</a> or call 1-800-501-3439 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's charge</a> and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

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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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	Not Covered	PCP Required Authorization may be required
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	Not Covered	---None--- Authorization may be required
	<a href="#">Preventive care/screening</a> /immunization	No charge	Not Covered	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
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: 20% <a href="#">coinsurance</a> ; Blood work: 20% <a href="#">coinsurance</a> ; EKG: 20% <a href="#">coinsurance</a>	Not covered	---None--- Authorization may be required
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	Not covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.independenthealth.com">www.independenthealth.com</a>	Preferred Generic Drugs (Tier 1)	\$10	Not covered	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	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	\$45 minimum on Tier 3 Prescriptions. 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)	20% <a href="#">coinsurance</a>	Not Covered	Authorization may be required
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	Not Covered	Authorization may be required

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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 immediate medical attention	<a href="#">Emergency room care</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	---None---
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	Not Covered	Must be deemed <u>medically necessary</u>
	<a href="#">Urgent care</a>	20% <u>coinsurance</u>	Not Applicable	Coverage based on Participating After Hours Care Centers
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Semi-private room, per admission Authorization may be required
	Physician/surgeon fees	\$0 <u>copay</u> / visit	Not Covered	---None--- Authorization may be required
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u>	Not Covered	---None--- Authorization may be required
	Inpatient services	20% <u>coinsurance</u>	Not Covered	Semi-private room, per admission Authorization may be required
If you are pregnant	Office visits	\$0 <u>copay</u> / visit	Not Covered	No charge after the initial diagnosis
	Childbirth/delivery professional services	Physician: No charge	Not Covered	---None---
	Childbirth/delivery facility services	Delivery: 20% <u>coinsurance</u>	Not Covered	Semi-private room, per admission
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	Not Covered	Unlimited visits per contract year Authorization may be required
	<a href="#">Rehabilitation services</a>	20% <u>coinsurance</u>	Not Covered	Up to 60 visits per contract year
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	Not Covered	Up to 60 visits per contract year
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	Not Covered	Semi-private room, per admission Up to 120 days per contract year Authorization may be required
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not Covered	Authorization may be required
	<a href="#">Hospice services</a>	\$0 <u>copay</u> / admission	Not Covered	---None---

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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 your child needs dental or eye care	Children's eye exam	\$0 copay / visit	Not covered	Once every 12 months
	Children's glasses	Single: \$10 Bifocal: \$10	Not covered	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency Care When Traveling Outside the U.S.</li> <li>• Private-Duty Nursing</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility Treatment</li> <li>• Routine Eye Care (Adult)</li> </ul>

**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](http://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](http://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](http://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](http://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.

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**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.*—————

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**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 <u>deductible</u>	<b>\$500</b>	■ The plan's overall <u>deductible</u>	<b>\$500</b>	■ The plan's overall <u>deductible</u>	<b>\$500</b>
■ <u>Specialist coinsurance</u>	<b>20%</b>	■ <u>Specialist coinsurance</u>	<b>20%</b>	■ <u>Specialist coinsurance</u>	<b>20%</b>
■ Hospital (facility) <u>coinsurance</u>	<b>20%</b>	■ Hospital (facility) <u>coinsurance</u>	<b>20%</b>	■ Hospital (facility) <u>coinsurance</u>	<b>20%</b>
■ Other <u>coinsurance</u>	<b>20%</b>	■ Other <u>coinsurance</u>	<b>20%</b>	■ Other <u>coinsurance</u>	<b>20%</b>
<p><b>This EXAMPLE event includes services like:</b>                      Specialist office visits (<i>prenatal care</i>)                      Childbirth/Delivery Professional Services                      Childbirth/Delivery Facility Services                      Diagnostic tests (<i>ultrasounds and blood work</i>)                      Specialist visit (<i>anesthesia</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Primary care physician office visits (<i>including disease education</i>)                      Diagnostic tests (<i>blood work</i>)                      Prescription drugs                      Durable medical equipment (<i>glucose meter</i>)</p>		<p><b>This EXAMPLE event includes services like:</b>                      Emergency room care (<i>including medical supplies</i>)                      Diagnostic test (<i>x-ray</i>)                      Durable medical equipment (<i>crutches</i>)                      Rehabilitation services (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$500
Copayments	\$30	Copayments	\$100	Copayments	\$0
Coinsurance	\$1,900	Coinsurance	\$500	Coinsurance	\$300
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$60	Limits or exclusions	\$60	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$2,490</b>	<b>The total Joe would pay is</b>	<b>\$1,160</b>	<b>The total Mia would pay is</b>	<b>\$800</b>

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.

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## 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, 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>