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

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-network: $2,500 Individual / $5,000 Family</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>For network providers $5,000 Individual / $10,000 Family; for out-of-network providers $10,000 Individual / $20,000 Family.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billed charges, penalty amounts, and non-covered services.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="http://www.independenthealth.com">www.independenthealth.com</a> or call 1-800-501-3439 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copay / visit</td>
<td>30% coinsurance</td>
<td>---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay / visit</td>
<td>30% coinsurance</td>
<td>---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>30% coinsurance</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services needed 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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: $40 copay / visit; Blood work: $0 copay / visit; EKG: $25 copay/ $40 copay / visit</td>
<td>30% coinsurance</td>
<td>---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$75 copay / visit</td>
<td>30% coinsurance</td>
<td>Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. Annual maximum copayment of $750 after deductible is met.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **If you need drugs to treat your illness or condition** | Preferred Generic Drugs (Tier 1)          | **In-Network Provider (You will pay the least)** | $10  
Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.  
Out-of-Network Provider (You will pay the most) | Not Covered  
Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees  
Emergency room care  
Emergency medical transportation  
Urgent care  
Facility fee (e.g., hospital room)  
Physician/surgeon fees  
---None--- |
| **If you have outpatient surgery**                      | Non-Preferred Generic Drugs (Tier 2)      | $30  
Out-of-Network Provider (You will pay the most) | Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.  
Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees  
Emergency room care  
Emergency medical transportation  
Urgent care  
Facility fee (e.g., hospital room)  
Physician/surgeon fees  
---None--- |
| **If you need immediate medical attention**             | Non-Preferred Brand Name Drugs (Tier 3)   | $50  
Out-of-Network Provider (You will pay the most) | Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.  
Facility fee (e.g., ambulatory surgery center)  
Physician/surgeon fees  
Emergency room care  
Emergency medical transportation  
Urgent care  
Facility fee (e.g., hospital room)  
Physician/surgeon fees  
---None--- |
| **If you have a hospital stay**                         | Facility fee (e.g., hospital room)        | $500  
Out-of-Network Provider (You will pay the most) | Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year  
Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.  
Facility fee (e.g., hospital room)  
Physician/surgeon fees  
---None--- |

---None---
<table>
<thead>
<tr>
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<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$25 copay / visit</td>
<td>30% coinsurance</td>
<td>Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$500 copay / admission</td>
<td>30% coinsurance</td>
<td>Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$0 copay / visit</td>
<td>30% coinsurance</td>
<td>No charge after the initial diagnosis</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Physician: $0 copay / procedure</td>
<td>30% coinsurance</td>
<td>Semi-private room, per admission Limit 1 copay per single contract / 2 copays per family contract per year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Delivery: $500 copay / admission</td>
<td>30% coinsurance</td>
<td>Semi-private room, per admission</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>$40 copay / visit</td>
<td>30% coinsurance</td>
<td>Up to 40 visits per contract year. Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$15 copay / visit</td>
<td>30% coinsurance</td>
<td>Up to 20 visits per contract year combined</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$15 copay / visit</td>
<td>30% coinsurance</td>
<td>---None---</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$250 copay / admission</td>
<td>30% coinsurance</td>
<td>Up to 45 days per contract year. Semi-private room, per admission. Limit 1 copay per single contract / 2 copays per family contract per year. Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$0 copay / admission</td>
<td>30% coinsurance</td>
<td>---None---</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's eye exam</td>
<td>$0 copay / visit</td>
<td>Not Covered</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Single: $50 Bifocal: $70</td>
<td>Not Covered</td>
<td>Contact EyeMed for additional options at 1-877-842-3348</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>---None---</td>
</tr>
</tbody>
</table>
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
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- 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
- Chiropractic Care
- Infertility Treatment

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 on how 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.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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)

- The plan’s overall deductible: $2500
- Specialist copayment: $40
- Hospital (facility) copayment: $500
- Other copayment: $40

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

Total Example Cost: $12700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2500</td>
<td>$2500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions: $60

The total Peg would pay is: $3160

Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $2500
- Specialist copayment: $40
- Hospital (facility) copayment: $500
- Other copayment: $40

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)

Total Example Cost: $7400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2500</td>
<td>$2500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions: $60

The total Joe would pay is: $2860

Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- The plan’s overall deductible: $2500
- Specialist copayment: $40
- Hospital (facility) copayment: $500
- Other copayment: $40

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: $1900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1900</td>
<td>$1900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered
- Limits or exclusions: $60

The total Mia would pay is: $1900

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.

무엇의 편에요, 또는 도와드릴 사람의 시점을 Independent Health에 대해 문의하시면 사용자가 자신의 언어로 무료로 도움과 정보를 받을 수 있습니다. 번역자와의 통화를 원하시면 1-800-501-3439로 전화해 주십시오.

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Kung ikaw, o ang iyang 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 makuasa ang 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 përkrtyes, 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)


General Taglines_Commercial
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