**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
**What is the overall deductible?** | In-network: $1,300 Individual / $2,600 Family 
Out-of-network: $5,000 Individual / $10,000 Family | 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

**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/](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 $7,900 Individual / $15,800 Family; for out-of-network providers: Unlimited | 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](http://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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
<td></td>
</tr>
<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>$30 copay / visit; 50% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay / visit; 50% 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; 50% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: $50 copay / visit; Blood work: $50 copay / visit; EKG: $30/$50 copay / visit</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>$50 copay / visit; 50% coinsurance</td>
<td>Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.</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>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred Generic Drugs (Tier 1)</td>
<td>$10</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Generic Drugs (Tier 2)</td>
<td>$35</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand Name Drugs (Tier 3)</td>
<td>$70</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$150 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 copay / visit</td>
<td>$250 copay / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150 copay / trip</td>
<td>$150 copay / trip</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 copay / visit</td>
<td>$70 copay / visit</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>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$1,500 copay / admission</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$150 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$30 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$1,500 copay / admission</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>$0 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>Physician: $150 copay / procedure</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>Delivery: $1,500 copay / admission</td>
<td>50% coinsurance</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>
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<tr>
<td>--------------------------------------</td>
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<td>--------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$50 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have</td>
<td>Rehabilitation services</td>
<td>$30 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>other special health needs</td>
<td>Habilitation services</td>
<td>$30 copay / visit</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$1,500 copay / admission</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>$1,500 copay / admission</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye</td>
<td>Children's eye exam</td>
<td>$30 copay / visit</td>
<td>Not Covered</td>
</tr>
<tr>
<td>care</td>
<td>Children's glasses</td>
<td>30% coinsurance</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</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)
- 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
- Hearing Aids
- 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 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.
In accordance with Section 1303 of the Patient Protection and Affordable Care Act, at least $1.00 of the total premium amount owed per enrollee per month is a payment for coverage of non-Hyde abortion services.

---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 prenatal care and a hospital delivery)

- The plan's overall deductible: $1300
- Specialist copayment: $50
- Hospital (facility) copayment: $1500
- Other copayment: $50

**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)

**Total Example Cost:** $12700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered:** Limits or exclusions $60

**The total Peg would pay is:** $3560

---

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

- The plan's overall deductible: $1300
- Specialist copayment: $50
- Hospital (facility) copayment: $1500
- Other copayment: $50

**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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn't covered:** Limits or exclusions $60

**The total Joe would pay is:** $2460

---

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

- The plan's overall deductible: $1300
- Specialist copayment: $50
- Hospital (facility) copayment: $1500
- Other copayment: $50

**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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn't covered:** Limits or exclusions $60

**The total Mia would pay is:** $1510

---

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

**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 konsénan 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.

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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 동역사와 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**
איבר ארץ, אוור תקצ_iters, אר פרנסט וتكو, אאראמסט גוואר.
אאראמסט גוואר. זא רעטן מיט דייער איברפריטס, קלאונט 3439.

1-800-501-3439

**Bangala-Bangali**
বলি আলোচনা, অথবা আলোচনা অন্য কাউকে সহায়তা করতে, সম্পর্কে প্রশ্ন আছে Independent Health, আপনার অধিকার আছেন বিনা খরচে আপনার নিজস্ব ভাষায় সাহায্য দাবার এবং ভাষ্য অনুসন্ধানের সাথে কথা বলার জন্য, 1-800-501-3439.

1-800-501-3439

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Nondiscrimination statement and language assistance services (cont’d)

Polish
Jeśli Ty lub osoba, której pomagasz, ma 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
إذا كان لديك أو لديه شخص تساعدك أسئلة بخصوص إستقلالية، فليس للتقاسم بدفع مبلغ من دون أي كلفة. للتحدث مع مترجم اتصل ب 1-800-501-3439.

Independent Health يلتزم بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو الجنس 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 اپ کسی کو مدی دریں ہے، تو اپہ دونوں کو اپنے زبان Independent Health کے بارے میں، ترجمان سے بات کرنے کے لئے، 1-800-501-3439 کو کہنی ہے۔

قانونی حقوق کے، ابتدائی حقوق کے، قانونی حقوق کے، تعلیم کرنے کے، اور ہے کہ نسل، رنگ، قومیت، عمر، مслужبوں کے جنسی گروہ کی بندی، امتیاز نہیں کرتا Independent Health.
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 ang isang tagasalin, tumawag sa 1-800-501-3439.

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

Greek
Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω από 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 qe 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 zbutëshme federale të të drejtave civile dhe nuk ushtron diskriminim mbi baza si raca, ngjyra, prejardhja etnike, mosha, aftësia e kufizuar ose gjinia.
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)