



This is only a summary. Please read the FEHB Plan brochure 73-103 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.independenthealth.com or by calling 1-800-501-3439.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	<p>\$500/self only</p> <p>\$1,000/self and family</p> <p>Applies to out-of-network benefits only</p>	<p>You must pay all the costs up to the deductible amount before this plan begins to pay for certain covered services you use. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1st. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible.</p>
Are there other deductibles for specific services?	No.	<p>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</p>
Is there an out-of-pocket limit on my expenses?	<p>In-Network: \$5,000/self only</p> <p>\$10,000/self and family</p> <p>Out-of-Network:</p> <p>\$5,000/self only</p> <p>\$10,000/self and family</p>	<p>The out-of-pocket limit, or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses.</p>
What is not included in the out-of-pocket limit?	<p>Premiums, deductibles, pharmacy liability, balance-billing, penalties, and non-covered services.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
Does this plan use a network of providers?	<p>Yes. See www.independenthealth.com or call 1-800-501-3439 for a list of participating providers.</p>	<p>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. [We use the terms preferred or participating for providers in our network.] See the chart starting on page 2 for how this plan pays different kinds of providers.</p>
Do I need a referral to see a specialist?	No.	<p>You can see the specialist you choose without the permission from this plan.</p>
Are there services this plan doesn't cover?	Yes.	<p>Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about excluded services.</p>

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

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care <u>provider’s</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	25% coinsurance	---None---
	Specialist visit	\$25 copay/visit	25% coinsurance	---None---
	Other practitioner office visit	Chiropractor: \$25 copay/visit Allergy injections: \$25 copay/visit	25% coinsurance	---None---
	Preventive care/screening/immunization	No charge	25% coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$25 copay/visit Blood work: No charge EKG: \$25 copay/visit	25% coinsurance	---None---

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Independent Health: HMO (High Option) – Encompass Plus

Coverage Period: 1/1/2015-12/31/2015

Summary of Benefits and Coverage

Coverage for: Self Only -or- Self and Family | Plan Type: HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	\$40 copay/visit	25% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. Authorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].	Generic drugs	\$10 copay/prescription	Not covered	Must be filled at a participating pharmacy Tier 1 oral contraceptives covered in full
	Preferred brand drugs	\$50 copay/prescription	Not covered	Must be filled at a participating pharmacy Tier 2 oral contraceptives covered in full
	Non-preferred brand drugs	50% coinsurance	Not covered	Must be filled at a participating pharmacy Select Tier 3 oral contraceptives covered in full
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$75 copay/visit	25% coinsurance	Authorization may be required
	Physician/surgeon fees	No charge	25% coinsurance	Authorization may be required
If you need immediate medical attention	Emergency room services	\$100 copay/visit	\$100 copay/visit	Copayment waived if admitted
	Emergency medical transportation	\$75 copay/trip	\$75 copay/trip	Must be deemed medically necessary
	Urgent care	\$50 copay/visit	Not covered	Coverage based on Participating After Hours Care Centers
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500 copay/admission	25% coinsurance	Semi-private room, per admission Authorization may be required
	Physician/surgeon fee	No charge	25% coinsurance	Authorization may be required

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$25 copay/visit	25% coinsurance	---None---
	Mental/Behavioral health inpatient services	\$500 copay/admission	25% coinsurance	Semi-private room, per admission Authorization may be required
	Substance use disorder outpatient services	\$25 copay/visit	25% coinsurance	---None---
	Substance use disorder inpatient services	\$500 copay/admission	25% coinsurance	Semi-private room, per admission Authorization may be required
If you are pregnant	Prenatal and postnatal care	No charge	25% coinsurance	No charge after the initial diagnosis
	Delivery and all inpatient services	\$500 copay/admission	25% coinsurance	Semi-private room, per admission Authorization may be required

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non- Participating Provider (plus you may be balance billed)	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	\$25 copay/visit	25% coinsurance	Authorization may be required
	Rehabilitation services	\$25 copay/visit	25% coinsurance	Up to 2 consecutive months of treatment per diagnosis per year for outpatient physical, occupational and speech therapies.
	Habilitation services	\$25 copay/visit	25% coinsurance	Up to 2 consecutive months of treatment per diagnosis per year for outpatient physical, occupational and speech therapies.
	Skilled nursing care	\$500 copay/admission	25% coinsurance	Up to 45 days per year Semi-private room, per admission Authorization may be required
	Durable medical equipment	50% coinsurance	50% coinsurance	---None---
	Hospice service	No charge	25% coinsurance	---None---
If your child needs dental or eye care	Eye exam	\$10 copay/visit	Not covered	One routine exam every 12 months
	Glasses	Single: \$50 Bifocal: \$70	Not covered	---None---
	Dental check-up	Not covered	Not covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for 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 foot care
- Weight loss programs

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Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov.insure/health.

Your Appeal Rights:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-501-3439 or visit www.opm.gov.insure/health.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **Coverage under this plan qualifies as minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

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

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

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About these Coverage Examples:

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



This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby (normal delivery)

- **Amount owed to providers: \$7,540**
- **Plan pays \$6,850**
- **Patient pays \$690**

Sample care costs:

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

Patient pays:

Deductibles	\$0
Copays	\$540
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$690

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$1,120**
- **Patient pays \$4,280**

Sample care costs:

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

Patient pays:

Deductibles	\$0
Copays	\$1,040
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$1,120

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

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