

**Independent Health: HMO (Standard Opt.) – Encompass Essential Coverage Period: 1/1/2015-12/31/2015**  
**Summary of Benefits and Coverage Coverage for: Self Only -or- Self and Family | Plan Type: HMO**



**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](http://www.independenthealth.com) or by calling 1-800-501-3439.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,000/self only \$2,000/self and family Applies to out-of-network benefits only	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for certain covered services you use. <b>Copayments</b> and <b>coinsurance</b> amounts do not count toward your <b>deductible</b> , which generally starts over January 1st. When a covered service or supply is subject to a <b>deductible</b> , only the Plan allowance for the service or supply counts toward the <b>deductible</b> . See the chart starting on page 2 for how much you pay for covered services after you meet the <b>deductible</b> and for which services are subject to the <b>deductible</b> .
Are there other deductibles for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	In-Network: <b>\$6,350</b> /self only <b>\$12,700</b> /self and family Out-of-Network: <b>\$6,350</b> /self only <b>\$12,700</b> /self and family	The <b>out-of-pocket limit</b> , 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.
What is not included in the out-of-pocket limit?	Premiums, deductibles, balance-billing, penalties, and non-covered services.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Does this plan use a network of providers?	Yes. See <a href="http://www.independenthealth.com">www.independenthealth.com</a> or call 1-800-501-3439 for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. [We use the terms <b>preferred</b> or participating for <b>providers</b> in our <b>network</b> .] See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a specialist?	No.	You can see the <b>specialist</b> you choose without the permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about <b>excluded services</b> .

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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	\$30 copay/visit	30% coinsurance	---None---
	Specialist visit	\$50 copay/visit	30% coinsurance	---None---
	Other practitioner office visit	Chiropractor: \$30 copay/visit Allergy injections: \$30/\$50 copay/visit	30% coinsurance	---None---
	Preventive care/screening/immunization	No charge	30% coinsurance	---None---
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: \$40 copay/visit Blood work: No charge EKG: \$35/\$50 copay/visit	30% coinsurance	---None---

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	Imaging (CT/PET scans, MRIs)	\$75 copay/visit	30% coinsurance	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 per person. Authorization may be required.
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="#">www.[insert]</a> .	Generic drugs	\$4 copay/ prescription	Not covered	Must be filled at a participating pharmacy Tier 1 oral contraceptives covered in full
	Preferred brand drugs	35% coinsurance/ prescription	Not covered	Must be filled at a participating pharmacy Tier 2 oral contraceptives covered in full
	Non-preferred brand drugs	50% coinsurance/ prescription	Not covered	Must be filled at a participating pharmacy Select Tier 3 oral contraceptives covered in full
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 copay/visit	30% coinsurance	Authorization may be required
	Physician/surgeon fees	No charge	30% coinsurance	Authorization may be required
<b>If you need immediate medical attention</b>	Emergency room services	\$150 copay/visit	\$150 copay/visit	Copayment waived if admitted
	Emergency medical transportation	\$100 copay/trip	\$100 copay/trip	Must be deemed medically necessary
	Urgent care	\$75 copay/visit	Not covered	Coverage based on Participating After Hours Care Centers
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$750 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required
	Physician/surgeon fee	Physician: \$30/\$50/visit Surgeon: No charge procedure	30% coinsurance	Authorization may be required

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<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay/visit	30% coinsurance	---None---
	Mental/Behavioral health inpatient services	\$750 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required
	Substance use disorder outpatient services	\$30 copay/visit	30% coinsurance	---None---
	Substance use disorder inpatient services	\$750 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required
<b>If you are pregnant</b>	Prenatal and postnatal care	No charge	30% coinsurance	No charge after the initial diagnosis
	Delivery and all inpatient services	Facility: \$750 copay/admission Physician: No charge Newborn: \$750 copay/child	30% coinsurance	Semi-private room, per admission Authorization may be required
<b>If you need help recovering or have other special health needs</b>	Home health care	\$30 copay/visit	30% coinsurance	Authorization may be required
	Rehabilitation services	\$30 copay/visit	30% coinsurance	Up to 20 visits per year
	Habilitation services	\$30 copay/visit	30% coinsurance	Up to 20 visits per year
	Skilled nursing care	\$750 copay/admission	30% coinsurance	Up to 30 days per year Semi-private room, per admission Authorization may be required
	Durable medical equipment	50% coinsurance	50% coinsurance	---None---
	Hospice service	No charge	30% coinsurance	---None---
<b>If your child needs dental or eye care</b>	Eye exam	\$20 copay/visit	Not covered	One routine exam every 12 months
	Glasses	Single: \$50 Bifocal: \$70	Not covered	---None---

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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
	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

**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
- Chiropractic care
- Infertility treatment
- 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](http://www.opm.gov/insure/health).

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## 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](http://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?

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 \$5,840
- Patient pays \$1,700

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$1,550
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$1,700</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$4,390
- Patient pays \$1,010

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$930
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,010</b>

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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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