Independent Health. Choice Plus Platinum

Coverage for: All Tier Levels | **Plan Type: POS**

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	Answers	Why This Matters:
What is the overall deductible?	In-Network: Network A: $0 Individual $0 Family / Network B: $1,500 Individual $3,000 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 policy, the overall family deductible must be met before the plan begins to pay.
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/.
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?	Network Providers: Network A: $4,500 Individual $9,000 Family / Network B: $4,500 Individual $9,000 Family 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 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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Network A: $10 copay / visit	Network B: 50% coinsurance	50% coinsurance	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.
	Specialist visit	Network A: $40 copay / visit	Network B: 50% coinsurance	50% coinsurance	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Preventive care/screening/immunization	Network A: No charge	Network B: No charge	50% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: Network A: $40 copay / visit; Blood work: Network A: $10 copay / visit; EKG: Network A: $10/$40 copay / visit	X-ray: Network B: 50% coinsurance; Blood work: Network B: 50% coinsurance; EKG: Network B: 50% coinsurance	50% coinsurance	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Imaging (CT/PET scans, MRIs)	Network A: $85 copay / visit	Network B: 50% coinsurance	50% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com	Preferred Generic Drugs (Tier 1)	Network A: $5	Network B: $5	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. In-Network Deductible does not apply.
	Non-Preferred Generic Drugs (Tier 2)	Network A: $30	Network B: $30	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. In-Network Deductible does not apply.
	Non-Preferred Brand Name Drugs (Tier 3)	Network A: 50%	Network B: 50%	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy. In-Network Deductible does not apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Network A: $75 copay / visit	Network B: 50% coinsurance	50% coinsurance	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Physician/surgeon fees	Network A: $0 copay / visit	Network B: 50% coinsurance	50% coinsurance	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you need immediate medical attention	Emergency room care	Network A: $150 copay / visit	Network B: $150 copay / visit	$150 copay / visit	In-Network Deductible does not apply Copay waived if admitted
	Emergency medical transportation	Network A: $150 copay / trip	Network B: $150 copay / trip	$150 copay / trip	Must be deemed medically necessary
	Urgent care	Network A: $75 copay / visit	Network B: 50% coinsurance	Network A: $75 copay / visit Network B: 50% coinsurance	---None---

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Network A: $500 copay / admission	Network B: 50% coinsurance	50% coinsurance	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Physician/surgeon fees	Network A: $0 copay / admission	Network B: 50% coinsurance	50% coinsurance	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Network A: $10 copay / visit	Network B: 50% coinsurance	50% coinsurance	---None--- Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Inpatient services	Network A: $500 copay / admission	Network B: 50% coinsurance	50% coinsurance	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
If you are pregnant	Office visits	Network A: $0 copay / visit	Network B: $0 copay / visit	50% coinsurance	No charge after the initial diagnosis
	Childbirth/delivery professional services	Physician: $0 copay	50% coinsurance	50% coinsurance	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Childbirth/delivery facility services	Network A: $500 copay / admission	50% coinsurance	50% coinsurance	Semi-private room, per admission

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		In-Network Preferred Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Network A: $40 copay / visit	Network B: 50% coinsurance	50% coinsurance	Up to 40 visits per plan year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Rehabilitation services	Network A: $40 copay / visit	Network B: 50% coinsurance	50% coinsurance	60 visits per condition, per plan year combined therapies
	Habilitation services	Network A: $40 copay / visit	Network B: 50% coinsurance	50% coinsurance	---None---
	Skilled nursing care	Network A: $500 copay / admission	Network B: 50% coinsurance	50% coinsurance	Semi-private room, per admission Unlimited days per plan year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Durable medical equipment	Network A: 50% coinsurance	Network B: 50% coinsurance	50% coinsurance	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.
	Hospice services	Network A: $0 copay / admission	Network B: 50% coinsurance	50% coinsurance	Up to 210 days per plan year
If your child needs dental or eye care	Children's eye exam	Network A: $20 copay / visit	Network B: $20 copay / visit	Not Covered	Once every 12 months
	Children's glasses	Network A: 30% coinsurance	Network B: 30% coinsurance	Not Covered	Once every 12 months. Contact EyeMed for additional options at 1-877-842-3348
	Children's dental check-up	Network A: Not Covered	Network B: Not Covered	Not Covered	---None---

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	• Long-Term Care	• Routine Eye Care (Adult)
• Cosmetic Surgery	• Non-Emergency Care When Traveling Outside the U.S.	• Routine Foot Care
• Dental Care (Adult)	• Private-Duty Nursing	• Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion Services	• Chiropractic Care	• Infertility Treatment
• Bariatric Surgery	• Hearing Aids	

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.
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 pre-natal care and a hospital delivery)

The plan's overall deductible	$0
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 (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1160

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

The plan's overall deductible	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$760

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

The plan's overall deductible	$0
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:

Cost Sharing	
Deductibles	$0
Copayments	$500
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$520

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.

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.

만약귀하또는귀하가돕고있는어떤사람이 Independent Health **에관해서질문이있다면귀하는그러한 도움과정보를귀하의언어로비용부담없이얻을수있는권리가 있습니다. 그렇게통역사와얘기하기 위해서는** 1-800-501-3439 **로전화하십시오.**

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 עמצער איר העלפסט. האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך
אומזיסט. צו רעדן מיט דער אי'בערזעצער, 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 তথ্য 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 تساعده أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات
الضرورية بلغتك من دون اية 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.

Independent Health

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**

Independent Health