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: $**4,50**0 Individual **$9,000** Family / Network B: $**4,50**0 Individual $**9,0**00 Family Out-of-Network Providers: $10,000 Individual / $20,000 Family | 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<br>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---<br>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.<br>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---<br>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. |
| | 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. |
| | 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. |
| **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 | 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--- |

**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**




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