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. Please read the FEHB Plan brochure (RI 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. 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 get the FEHB Plan brochure at www.Independenthealth.com, and view the Glossary at www.Independenthealth.com. You can call 1-800-501-3439 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 Copay Applies to in-network benefits only **$1,000**/Self Only **$2,000**/Self Plus One **$2,000**/Self and Family Applies to out-of-network benefits only	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. 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 Services	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 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?	**$8,700**/Self Only **$17,400**/Self Plus One **$17,400**/Self and Family In-Network **$10,000**/Self Only **$20,000**/Self Plus One **$20,000**/Self and Family Out-of-Network	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 limit limits until the overall family out–of–pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, penalties for failure to obtain pre-authorization for services, and healthcare this plan doesn't cover.	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 participating 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/visit	30% coinsurance	Authorization may be required.
	Specialist visit	$50/visit	30% coinsurance	Authorization may be required.
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $50/visit Blood work: No charge EKG: $30/$50/visit	30% coinsurance	Authorization may be required.
	Imaging (CT/PET scans, MRIs)	$75/visit	30% coinsurance	Annual maximum copayment of $750 per person. Authorization may be required.

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at IndependentHealth.com	Generic drugs	$7/prescription /30-day supply $17.50/ prescription/ 90-day supply	Not covered	Must be filled at a participating retail or mail order pharmacy Tier 1 oral contraceptives covered in full
	Preferred brand drugs	35% coinsurance	Not covered	Must be filled at a participating retail or mail order pharmacy Tier 2 oral contraceptives covered in full
	Non-preferred brand drugs	50% coinsurance	Not covered	Must be filled at a participating retail or mail order pharmacy Select Tier 3 oral contraceptives covered in full
	Preferred Specialty Drugs	35% coinsurance	Not covered	Must be filled at a participating retail or mail order pharmacy
	Non-preferred Specialty Drugs	50% coinsurance	Not covered	Must be filled at a participating retail or mail order pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100/visit	30% coinsurance	Authorization may be required
	Physician/surgeon fees	No charge	30% coinsurance	Authorization may be required
If you need immediate medical attention	Emergency room care	$150/visit	$150/visit	Copayment waived if admitted
	Emergency medical transportation	$100/trip	$100/trip	---None---
	Urgent care	$75/visit	$75/visit	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$750/admission	30% coinsurance	Authorization may be required
	Physician/surgeon fees	No charge	30% coinsurance	---None---

If you need mental health, behavioral health, or substance misuse disorder services	Outpatient services	$30/visit	30% coinsurance	---None---
	Inpatient services	$750/admission	30% coinsurance	Authorization may be required
If you are pregnant	Office visits	No charge	30% coinsurance	No charge after the initial diagnosis. Depending on the type of services, a, copayment, coinsurance, deductible may apply.
	Childbirth/delivery professional services	No charge	30% coinsurance	---None---
	Childbirth/delivery facility services	$750/admission	30% coinsurance	Authorization may be required
If you need help recovering or have other special health needs	Home health care	$50/visit	30% coinsurance	Authorization may be required. Up to 40 visits per year
	Rehabilitation services	$50/visit	30% coinsurance	Up to 20 visits per year
	Habilitation services	$50/visit	30% coinsurance	Up to 20 visits per year
	Skilled nursing care	$750/admission	30% coinsurance	Up to 45 days per year Authorization may be required
	Durable medical equipment	50% coinsurance	50% coinsurance	---None---
	Hospice services	No charge	30% coinsurance	---None---
If your child needs dental or eye care	Children's eye exam	$50/visit	30% coinsurance	---None---
	Children's glasses	Not covered	Not covered	---None---
	Children's dental check-up	Not covered	Not covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan's FEHB brochure for more information and a list of any 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 (Limitations may apply to these services. This isn't a complete list. Please see your plan's FEHB brochure.)

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

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. 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. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage 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: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact our Customer Service Department by writing: Independent Health, 511 Farber Lakes Drive, Buffalo NY 14221 or calling 716-631-8701 or 800-501-3439.

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 the 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:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-501-3439.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-501-3439.
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 1-800-501-3439.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-501-3439.

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** **$50**
- **Hospital (facility)** **$750**
- **Other** **$0**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$860**

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** **$50**
- **Hospital (facility)** **$750**
- **Other** **$0**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,360**

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

- **The plan's overall deductible** **$0**
- **Specialist** **$50**
- **Hospital (facility)** **$750**
- **Other** **$0**

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	**$2,800**

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**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.