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. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-257-2753 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0 for First Choice Tier 1, Par Physicians, Ancillary (IHC Network) & Specialty Services** Out-of-Network **$2,000 Individual / $4,000 Family** for Non-First Choice Facilities & Out-of-Network	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive services are covered before you meet your 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 a deductible for specific services.
What is the out-of-pocket limit for this plan?	**Pharmacy: $1,600 individual/ $3,200 family.** For network providers & out-of-network **$5,000 Individual / $10,000 Family** First Choice Providers, Specialty Services Non-First Choice Facilities, Par Physicians, Ancillary (IHC Network) & 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 limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Cost Containment penalties, Copayments for certain services, premiums, balance-billing charges (unless balanced billing is prohibited, and health care services 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 1-800-257-2753 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 choose to see the specialist you choose without 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
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: $10 copay/visit Child: $20 copay/visit	N/A	N/A	Adult: $10 copay/visit Child: $20 copay/visit	20% coinsurance	If you receive a blood or specimen draw during your office visit, you are responsible for the office visit copay only. 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. Routine physicals are not covered out of network.
	Specialist visit	$20 copay/ visit	N/A	N/A	$20 copay/ visit	20% coinsurance	
	Preventive care/screening/ immunization	N/A	N/A	N/A	No charge	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	EKG: No charge X-Ray: $20 copay/ visit Blood work: No charge	EKG & X-Ray: $20 copay/ visit Blood work: No charge	EKG & X-Ray: 20% coinsurance/ Visit Blood work: 20% coinsurance/ visit	EKG: PCP: Adult:$10 copay/visit Child: $20 copay/visit Specialist: $20 copay/ visit X-Ray: $20 copay/ visit	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
					Blood work: Independent Lab: 20% coinsurance/ visit Doctor office: No charge		
If you have a test	Imaging (CT/PET scans, MRIs)	$20 copay/ visit	$20 copay/ visit	20% coinsurance/ visit	$20 copay/ visit	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pbdrx.com	Generic drugs / Tier 1	N/A	N/A	N/A	30-day supply: $5 copay 90-day supply: Mail order: $12.50 copay Retail: $15 copay	N/A	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	Preferred brand drugs / Tier 2	N/A	N/A	N/A	30-day supply: $25 copay 90-day supply: Mail order: $62.50 copay Retail: $75 copay	N/A	

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pbdrx.com	Non-preferred brand drugs / Tier 3	N/A	N/A	N/A	30-day supply: $50 copay 90-day supply: Mail order: $125 copay Retail: $150 copay	N/A	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	Specialty drugs (Tier 4)	N/A	N/A	N/A	Designated by Manufacturer Discount Program	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 copay/ visit	$125 copay/ visit	20% coinsurance/ visit	N/A	20% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Physician/surgeon fees	No charge	No charge	20% coinsurance/ visit	No charge	20% coinsurance	-None-
If you need immediate medical attention	Emergency room care	$250 copay/ visit	$250 copay/ visit	$250 copay/ visit	N/A	$250 copay/ visit	Copayment waived if admitted.
	Emergency medical transportation	N/A	N/A	N/A	$100 copay/ trip	$100 copay/ trip	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	N/A	N/A	N/A	$50 copay/ visit	$50 copay/ visit	Coverage for Participating After Hours Urgent care centers.

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	$500 copay/ admission*	20% coinsurance/ admission*	N/A	20% coinsurance	*If admitted through ER, no charge. Limit 1 copay per individual /2 copays per family/ plan year. Member precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. Semi-private room, per admission
	Physician/surgeon fees	No charge	No charge	20% coinsurance/ visit	No charge	20% coinsurance	-None-
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: $10 copay/visit Child: $20 copay/visit	Adult: $10 copay/visit Child: $20 copay/visit	20% coinsurance/ visit	Adult: $10 copay/visit Child: $20 copay/visit	20% coinsurance	
	Inpatient services	No charge*	$500 copay/ admission	20% coinsurance/ admission	N/A	20% coinsurance	*If admitted through ER, no charge. Limit 1 copay per individual /2 copays per family/ plan year. Member precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. Semi-private room, per admission

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
If you are pregnant	Office visits	N/A	N/A	N/A	No charge after initial diagnosis	20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). If a visit is unrelated to Pregnancy, member liability may apply based on services rendered.
	Childbirth/delivery professional services	N/A	N/A	N/A	No charge	20% coinsurance	Member precertification may be required for Home Births.
	Childbirth/delivery facility services	No charge	$500 copay/ admission	20% coinsurance/ admission	N/A	20% coinsurance	Limit 1 copay per individual / 2 copays per family/ plan year. Member precertification may be required for Home Births.
If you need help recovering or have other special health needs	Home health care	$20 copay/ visit	N/A	**Erie & Niagara County:** 20% coinsurance/ visit **All other WNY Counties:** $20 copay/ visit	$20 copay/ visit	20% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non-First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
	Rehabilitation services	$20 copay/ visit	$20 copay/ visit	20% coinsurance/ visit	$20 copay/ visit	20% coinsurance	20 visits/plan year. Combined network providers & out- of-network providers. Includes physical therapy, speech therapy, and occupational therapy.
If you need help recovering or have other special health needs	Habilitation services	Not covered	Not covered	Not covered	Not covered	Not covered	--None--
	Skilled nursing care	No charge*	$500 copay/ admission**	20% coinsurance/ admission**	N/A	20% coinsurance **	*90 days/plan year. **45 days/plan year which counts towards the 90-day limit. Limit 2 copays per family / plan year. Member precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Durable medical equipment	N/A	N/A	N/A	20% coinsurance*	50% coinsurance	Member precertification may be required.
	Hospice services	No charge	No charge	No charge	N/A	20% coinsurance	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A	N/A	N/A	Covered through EyeMed 1-877-842-3348
	Children's glasses	N/A	N/A	N/A	N/A	N/A	
	Children's dental check-up	Not covered.	Not covered.	Not covered.	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	• Infertility treatment	• Private-duty nursing
• Cosmetic Surgery	• Long-term care	• Routine eye care (Adult)
• Dental Care (Adult)	• Non-emergency care when traveling outside the U.S	• Routine foot care
• Hearing aids		• Weight loss programs

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

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. 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: 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 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 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 1-800-257-2753

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-257-2753

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-257-2753

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-257-2753

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

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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	**$20**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

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	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$100**

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	**$20**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

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	$600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$655**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

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	$440
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$447**

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