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?	Out-of-Network providers: $500 Individual / $1,000 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 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 $5,000 Individual / $10,000 Family. For out-of-network providers $2,500 Individual / $5,000 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?	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.

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(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

Important Questions	Answers	Why This Matters:
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
		Network Provider (You will pay the least)	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	$20 copay/visit	20% 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.
	Specialist visit	$30 copay/visit	20% coinsurance	
	Preventive care/screening/ immunization	No charge	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	EKG: PCP: $20 copay/visit Specialist: $30 copay/visit X-Ray: $20 copay/visit Blood work: No charge	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	$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)	30-day supply: $10 copay 90-day supply: Mail order & Retail: $20 copay	Not covered	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy

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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.pbdrx.com	Preferred brand drugs (Tier 2)	30-day supply: $30 copay 90-day supply: Mail order & Retail: $60 copay	Not covered	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	Non-preferred brand drugs (Tier 3)	30-day supply: $55 copay 90-day supply: Mail order & Retail: $110 copay	Not covered	
	Specialty drugs (Tier 4)	Designated by Manufacturer Discount Program		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit	20% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses.
	Physician/surgeon fees	No charge	20% coinsurance	-None-
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	Copayment waived if admitted.
	Emergency medical transportation	$25 copay/trip	$25 copay/trip	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	$50 copay/visit	$50 copay/visit	Coverage for Participating After Hours Urgent care centers.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	20% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses. Semi-private room, per admission
	Physician/surgeon fees	No charge	20% coinsurance	-None-

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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay/visit	20% coinsurance	-None-
	Inpatient services	No charge	20% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses. Semi-private room, per admission
If you are pregnant	Office visits	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	No charge	20% coinsurance	Member precertification may be required for Home Births. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses.
	Childbirth/delivery facility services	No charge	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	$20 copay/visit	20% coinsurance	40 visits/plan year. Combined network providers & out- of-network providers. Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses.
	Rehabilitation services	$20 copay/visit	20% coinsurance	20 visits/year. Combined network providers & out- of-network providers. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not covered	Not covered	-None-
	Skilled nursing care	No charge	20% coinsurance	45 days/plan year. Combined network providers & out- of-network providers. Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses.

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	Member precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses.
	Hospice services	No charge	20% coinsurance	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered through EyeMed 1-877-842-3348
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	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
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)
- 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 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	**$30**
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	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$160**

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	**$30**
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	$920
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$975**

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

The plan's overall deductible	**$0**
Specialist copayment	**$30**
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	$265
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$272**

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