




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, 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?	Combined network providers and out-of-network providers: \$1,700 Individual \$3,400 / 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 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?	For network providers \$5,000 Individual / \$10,000 Family; for 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 , the overall family out-of-pocket limits must be met pay these expenses.
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
		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	\$15 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	\$15 copay /visit	20% coinsurance	
	Preventive care/screening/immunization	No charge. Deductible does not apply	20% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	EKG & Xray : \$15 copay /visit	20% coinsurance	
	Imaging (CT/PET scans, MRIs)	Blood work : No charge \$15 copay /test	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: \$5 copay 90-day supply: Mail order & Retail Pharmacy: \$12.50 copay	Not covered	
	Preferred brand drugs (Tier 2)	30-day supply: \$15 copay 90-day supply: Mail order & Retail Pharmacy: \$37.50 copay	Not covered	

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	Non-preferred brand drugs (Tier 3)	30-day supply: \$30 copay 90-day supply: Mail order & Retail Pharmacy: \$75 copay	Not covered	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	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 precertify could result in member responsibility.
	Physician/surgeon fees	No charge.	20% coinsurance	-None-
If you need immediate medical attention	Emergency room care	\$50 copay /visit	\$50 copay /visit	Copayment waived if admitted.
	Emergency medical transportation	\$50 copay /trip	\$50 copay /trip	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	\$15 copay /visit	\$15 copay /visit	Coverage for Participating After Hours Urgent care centers.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay /admission	20% coinsurance	Member precertification may be required. Failure to precertify could result in member responsibility. Semi-private room, per admission.
	Physician/surgeon fees	No charge	20% coinsurance	-None-
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay /visit	20% coinsurance	Member precertification may be required. Failure to precertify could result in member responsibility.
	Inpatient services	\$250 copay /admission	20% coinsurance	Member precertification may be required. Failure to precertify could result in member responsibility. Semi-private room, per admission

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 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	
	Childbirth/delivery facility services	\$250 copay /admission	20% coinsurance	-None-
If you need help recovering or have other special health needs	Home health care	\$15 copay /visit	20% coinsurance	40 visits/plan year. Member precertification may be required. Failure to precertify could result in member responsibility.
	Rehabilitation services	\$15 copay /visit	20% coinsurance	30 visits/year. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not covered	Not covered	-None-
	Skilled nursing care	\$250 copay /admission	20% coinsurance	60 days/plan year. Member precertification may be required. Failure to precertify could result in member responsibility.
	Durable medical equipment	50% coinsurance	50% coinsurance	Member precertification may be required. Failure to precertify could result in member responsibility.
	Hospice services	\$15 copay /admission	20% coinsurance	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	For additional options, contact EyeMed at 1-877-842-3348
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Covered through Guardian 1-800-541-7846

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

For more information about limitations and exceptions, contact your Human Resources Department.

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|---|--|---|
| <ul style="list-style-type: none">• Cosmetic surgery• Dental care (Adult)• Hearing aids | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S | <ul style="list-style-type: none">• 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.)

- | | |
|---|---|
| <ul style="list-style-type: none">• Bariatric surgery | <ul style="list-style-type: none">• 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, kwijigo holne' 1-800-257-2753

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	\$1,700
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ 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:

<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$570
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,330

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,700
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ 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:

<i>Cost Sharing</i>	
Deductibles*	\$1,700
Copayments	\$870
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,625

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,700
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ 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:

<i>Cost Sharing</i>	
Deductibles*	\$1,656
Copayments	\$270
Coinsurance	\$18
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,945

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.