




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 <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$500 Individual / \$1,000 Family <a href="#">Out-of-network</a> providers: \$4,000 / Individual \$8,000 / Family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive services</a> are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet a <a href="#">deductible</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$2,500 Individual / \$5,000 Family; for <a href="#">out-of-network</a> providers \$10,000 Individual / \$20,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limits</a> must be met pay these expenses
What is not included in the <a href="#">out-of-pocket limit</a> ?	Cost Containment penalties, <a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges (unless balanced billing is prohibited, and health care services this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.independenthealth.com">www.independenthealth.com</a> or call 1-800-257-2753 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can choose to see the <a href="#">specialist</a> 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 <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">EKG &amp; X-ray</a> : 10% <a href="#">coinsurance</a> /visit <a href="#">Blood work</a> : 10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.pbdrx.com">www.pbdrx.com</a>	Generic drugs (Tier 1)	30-day supply: \$5 <a href="#">copay</a> 90-day supply: Mail order & Retail Pharmacy: \$12.50 <a href="#">copay</a>	Not covered	
	Preferred brand drugs (Tier 2)	30-day supply: \$15 <a href="#">copay</a> 90-day supply: Mail order & Retail Pharmacy: \$37.50 <a href="#">copay</a>	Not covered	

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

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.pbdrx.com">www.pbdrx.com</a>	Non-preferred brand drugs (Tier 3)	30-day supply: \$30 <a href="#">copay</a>  90-day supply: Mail order & Retail Pharmacy: \$75 <a href="#">copay</a>	Not covered	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	<a href="#">Specialty drugs</a> (Tier 4)	Designated by Manufacturer Discount Program		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	-None-
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a> /visit	10% <a href="#">coinsurance</a> /visit	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a> /trip	10% <a href="#">coinsurance</a> /trip	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a> /visit	10% <a href="#">coinsurance</a> /visit	Coverage for Participating After Hours <a href="#">Urgent care</a> centers.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> / admission	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility. Semi-private room, per admission.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	-None-
<b>If you need mental health, behavioral health, or substance</b>	Outpatient services	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.

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)	
<b>abuse services</b>	Inpatient services	10% <a href="#">coinsurance</a> / admission	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Semi-private room, per admission
<b>If you are pregnant</b>	Office visits	No charge after initial diagnosis	50% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> 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	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	-None-
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> / admission	50% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$20 <a href="#">copay</a> /visit	50% <a href="#">coinsurance</a>	40 visits/plan year. . Combined <a href="#">network providers</a> and <a href="#">out-of-network</a> providers. Member <a href="#">precertification</a> may be required.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a> /visit	50% <a href="#">coinsurance</a>	30 visits/year. Combined <a href="#">network providers</a> and <a href="#">out-of-network</a> providers. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	Not covered	Not covered	-None-
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> / admission	50% <a href="#">coinsurance</a>	60 days/plan year. Combined <a href="#">network providers</a> and <a href="#">out-of-network</a> providers. Member <a href="#">precertification</a> may be required.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> / admission	50% <a href="#">coinsurance</a>	210 days/plan year. Hospice services shall include supplies & drugs.
<b>If your child needs</b>	Children's eye exam	Not covered	Not covered	For additional options, contact EyeMed at

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

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)	
dental or eye care	Children's glasses	Not covered	Not covered	1-877-842-3348
	Children's dental check-up	Not covered	Not covered	Covered through Guardian 1-800-541-7846

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	

**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](http://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](http://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.*

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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](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 50%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$1,240
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,860</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 50%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$500
<a href="#">65</a>	\$680
<a href="#">Coinsurance</a>	\$13
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,249</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$20
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 50%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a> *	\$500
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$178
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$738</b>

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