




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> ?	<a href="#">Out-of-network</a> providers: \$500/ Individual \$1,000 / 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 <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
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> \$6,350 Individual / \$12,700 Family; for <a href="#">out-of-network</a> providers \$5,000 Individual / \$10,000 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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
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</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> /visit	25% <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	\$25 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply	25% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	<a href="#">EKG &amp; Xray</a> : \$25 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	
	Imaging (CT/PET scans, MRIs)	<a href="#">Blood work</a> : No charge \$25 <a href="#">copay</a> /test	25% <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: \$15 <a href="#">copay</a> 90-day supply: Mail order & Retail Pharmacy: \$37.50 <a href="#">copay</a>	Not covered	Mail order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy
	Preferred brand drugs (Tier 2)	30-day supply: \$30 <a href="#">copay</a> 90-day supply: Mail order & Retail Pharmacy: \$75 <a href="#">copay</a>	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)	
<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: \$50 <a href="#">copay</a> 90-day supply Mail order & Retail Pharmacy: \$125 <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)	\$75 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.
	Physician/surgeon fees	No charge	25% <a href="#">coinsurance</a>	-None-
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$75 <a href="#">copay</a> /visit	\$75 <a href="#">copay</a> /visit	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$50 <a href="#">copay</a> /trip	\$50 <a href="#">copay</a> /trip	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	<a href="#">Urgent care</a>	\$35 <a href="#">copay</a> /visit	\$35 <a href="#">copay</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)	\$250 <a href="#">copay</a> /admission	25% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. One <a href="#">copay</a> per a member per plan year; Two <a href="#">copay</a> per family per a plan year. Failure to precertify could result in member responsibility. Semi-private room, per admission.
	Physician/surgeon fees	No charge	25% <a href="#">coinsurance</a>	-None-
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$25 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required.
	Inpatient services	\$250 <a href="#">copay</a> /admission	25% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. One <a href="#">copay</a> per a member per plan year; Two <a href="#">copay</a> per family per a plan year. 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)	
<b>If you are pregnant</b>	Office visits	No charge after initial diagnosis	25% <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	No charge	25% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	\$250 <a href="#">copay</a> /admission	25% <a href="#">coinsurance</a>	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$25 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	365 visits/plan year. Combined <a href="#">network providers</a> and <a href="#">out-of-network providers</a> Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.
	<a href="#">Rehabilitation services</a>	\$25 <a href="#">copay</a> /visit	25% <a href="#">coinsurance</a>	20 visits/year. Combined <a href="#">network providers</a> and <a href="#">out-of-network providers</a> Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	Not covered	Not covered	-None-
	<a href="#">Skilled nursing care</a>	\$250 <a href="#">copay</a> /admission	25% <a href="#">coinsurance</a>	50 days/plan year. Combined <a href="#">network providers</a> and <a href="#">out-of-network providers</a> . One <a href="#">copay</a> per a member per plan year; Two <a href="#">copay</a> per family per a plan year. Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Member <a href="#">precertification</a> may be required. Failure to precertify could result in member responsibility.
	<a href="#">Hospice services</a>	No charge. <a href="#">Deductible</a> does not apply	25% <a href="#">coinsurance</a>	210 days/plan year. Hospice services shall include supplies & drugs.

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 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.)**

<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>
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**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"> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>
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**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](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 25%

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>	\$0
<a href="#">Copayments</a>	\$385
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$445</b>

### 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](#) \$25
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 25%

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>	\$0
<a href="#">Copayments</a>	\$1,365
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,420</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$25
- Hospital (facility) [copayment](#) \$250
- Other [coinsurance](#) 25%

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>	\$0
<a href="#">Copayments</a>	\$425
<a href="#">Coinsurance</a>	\$18
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$443</b>

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