




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, please contact your Human Resources Department. 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 <http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf>, or call 1-800-257-2753 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	In-Network: \$0 Out-of-Network: \$150 Individual / \$300 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before the plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes	Preventive care. This plan covers items and services even if you haven't met the deductible amount. But a copayment or coinsurance may apply.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	In-Network: \$0 Out-of-Network: \$1,250 Individual / \$2,500 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Cost Containment Penalties, Premiums, Balance-billed Charges (unless balance billing is prohibited), health care services this plan doesn't cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.independenthealth.com for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	20% coinsurance after Deductible	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	20% coinsurance after Deductible	--None--
	Preventive care/screening/immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: \$15 copay Laboratory: No charge	20% coinsurance after Deductible	--None--
	Imaging (CT/PET scans, MRIs)	\$15 copay	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
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	Retail: 20% coinsurance Mail Order: 20% coinsurance	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply
	Preferred brand drugs / Tier 2	Retail: 20% coinsurance Mail Order: 20% coinsurance	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply
	Non-preferred brand drugs / Tier 3	Retail: 20% coinsurance Mail Order: 20%	Not covered.	Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply

* For more information about limitations and exceptions, please 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)	
		coinsurance		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$50 copay	20% coinsurance after Deductible	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	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
If you need immediate medical attention	<u>Emergency room care</u>	\$50 copay	Covered as in-network benefit	Copayment waived if admitted
	<u>Emergency medical transportation</u>	\$75 copay	Covered as in-network benefit	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	<u>Urgent care</u>	\$15 copay	Not Applicable	Coverage based on Participating After Hours Urgent Care Center
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay	20% coinsurance after Deductible	Maximum 1 copay per individual/ 2 copays per family per year. Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of \$500 for each instance.
	Physician/surgeon fees	No charge	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of \$500 for each instance.

* For more information about limitations and exceptions, please 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)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay	20% coinsurance after Deductible	-None-
	Inpatient services	\$250 copay	20% coinsurance after Deductible	Maximum 1 copay per individual/ 2 copays per family per year. Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of \$500 for each instance.
If you are pregnant	Office visits	No charge after initial diagnosis	20% coinsurance after Deductible	Cost sharing does not apply for preventative services. If a visit is unrelated to Pregnancy, member liability may apply based on services rendered.
	Childbirth/delivery professional services	No charge	20% coinsurance after Deductible	Member Precertification may be required for Home Births. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of \$500 for each instance.
	Childbirth/delivery facility services	No charge	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of \$500 for each instance.
If you need help recovering or have other special health needs	Home health care	\$15 copay	20% coinsurance after Deductible	Up to 365 visits per plan year. In and Out-of-Network combined equal total benefit.
	Rehabilitation services	\$15 copay	20% coinsurance after Deductible	Up to 20 visits per plan year (combined). In and Out-of-Network combined equal total benefit.
	Habilitation services	Not covered.	Not covered.	-None-
	Skilled nursing care	\$0 copay	20% coinsurance after Deductible	Up to 120 days per plan year. In and Out-of-Network combined equal total benefit. Member Precertification may be required. Failure to obtain precertification could result in up to a

* For more information about limitations and exceptions, please 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)	
				50% reduction of the eligible expenses up to a maximum of \$500 for each instance.
	Durable medical equipment	\$15 copay	20% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Hospice services	No charge	20% coinsurance after Deductible	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	--None--
	Children's glasses	Not covered.	Not covered.	--None--
	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	• Dental care (Adult)	• Non-Emergency care when traveling outside the US
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)
• Cosmetic Surgery	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Private-duty nursing	
• Infertility treatment	• Routine foot 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. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact: Independent Health at 1-800-257-2753.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.*—————

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 \$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	\$12,731
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$150
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$210

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 \$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	\$7,389
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$35
Coinsurance	\$115
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$205

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

- The [plan's](#) overall [deductible](#) \$0
- [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	\$1,925
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$150
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$150