




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> to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | In-Network: \$0 Out-of-Network: \$500 Individual / \$1,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before the 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 | Preventative 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 deductibles for specific services? | No | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | In-Network: \$6,350 Individual / \$12,700 Family Out-of-Network: \$5,000 Individual / \$10,000 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, 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 out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See www.independenthealth.com 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 see the specialist you choose without a 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 | Adult (19+): \$15 copay Child (0-18): No charge | 25% 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. Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. |
| | Specialist visit | \$15 copayment | 25% 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. |
| | Preventive care/screening/immunization | No charge | 25% coinsurance after Deductible | Certain preventive services are not covered when they are provided out-of-network. You may have to pay for services. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Immunizations provided to those over 19 years of age are not covered out-of-network. Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-Ray: Adult (19+) PCP Office \$15 copayment Child (0-18): No charge Specialist Office: \$15 copayment Laboratory: No charge | 25% 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. |
| | Imaging (CT/PET scans, | \$15 copayment | 25% coinsurance after | Member Precertification may be required. |

* 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) | |
| | MRIs) | | Deductible | 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 | Retail: \$5 Copay Mail order: \$12.50 Copay | Not covered. | Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply |
| | Preferred brand drugs | Retail: \$15 Copay Mail order: \$37.50 Copay | Not covered. | Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply |
| | Non-preferred brand drugs | Retail: \$30 Copay Mail order: \$75 Copay | Not covered. | Must be filled at a participating pharmacy. Retail: 30 day supply Mail Order: 90 day supply |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$15 copayment | 25% coinsurance after Deductible | Member Precertification may be required. |
| | Physician/surgeon fees | No charge | 25% coinsurance after Deductible | Member Precertification may be required. |
| If you need immediate medical attention | Emergency room care | \$50 copayment | Covered as in-network benefit | Copayment waived if admitted |
| | Emergency medical transportation | \$50 copayment | Covered as in-network benefit | Must be deemed medically necessary. Wheelchair van transportation is not covered. |
| | Urgent care | In a physician's office: Adult (19+): \$15 copay After Hours Care Center: \$15 copayment | In a physician's office: 25% coinsurance after Deductible After Hours Care Center: Not applicable | -None- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 25% coinsurance after Deductible | Member Precertification may be required. Failure to obtain precertification could result in covered person being responsible for the first \$1,200 for each instance. |
| | Physician/surgeon fees | No charge | 25% coinsurance after Deductible | -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 copayment | 25% 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. |
| | Inpatient services | No charge | 25% coinsurance after Deductible | Member Precertification may be required. Failure to obtain precertification could result in covered person being responsible for the first \$1,200 for each instance |
| If you are pregnant | Office visits | No charge after initial diagnosis | 25% 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 | 25% coinsurance after Deductible | Member Precertification may be required for Home Births. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. |
| | Childbirth/delivery facility services | No charge | 25% coinsurance after Deductible | -None- |
| If you need help recovering or have other special health needs | Home health care | \$15 copayment | 25% coinsurance after Deductible | Maximum of 365 visits per plan year. Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance. Custodial services and long-term therapy are not covered. |
| | Rehabilitation services | \$15 copayment | 25% coinsurance after Deductible | Maximum of 20 visits per plan year (Physical Therapy, Speech Therapy, Occupational Therapy combined). In-network & out-of-network services combined equal total benefit. Custodial services and long-term therapy are not covered. |
| | Habilitation services | Not covered. | Not covered. | -None- |
| | Skilled nursing care | No charge | 25% coinsurance after Deductible | Up to 50 visits per plan year. Member Precertification may be required. Failure to |

| 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) | |
| | | | | obtain precertification could result in covered person being responsible for the first \$1,200 for each instance. Custodial services and long-term therapy are not covered. |
| | Durable medical equipment | 50% coinsurance | 50% 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 | 25% coinsurance after Deductible | Maximum of 210 day limit per plan year. Hospice services shall include supplies & drugs. |
| If your child needs dental or eye care | Children's eye exam | Covered by EyeMed | Not covered. | Once every 12 months. |
| | Children's glasses | Covered by EyeMed | Not covered. | Contact EyeMed for additional options at 1-877-842-3348 |
| | 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 | ▪ Hearing aids | ▪ Routine foot care |
| ▪ Bariatric surgery | ▪ Long-term care | ▪ Weight loss programs |
| ▪ Cosmetic Surgery | ▪ Non-Emergency care when traveling outside the US | |
| ▪ Dental care (Adult) | Private-duty nursing | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
|--|----------------------------|--|
| • Chiropractic care | • Routine eye care (Adult) | |
| ▪ Infertility treatment | | |

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 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: 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

[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): Dinekehgo 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 | \$15 |
| ■ Hospital (facility) copayment | \$0 |
| ■ 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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$65 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$125 |

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 | \$0 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$500 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$555 |

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 | \$0 |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$270 |
| Coinsurance | \$18 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$288 |

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