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**: $500 Individual/ $1,000 Family **Out-of-Network**: $4,000 Individual / $8,000 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, an individual family member will not stop at their own individual deductible until the total amount of deductible expenses paid by any family member 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**: $2,500 Individual / $5,000 Family **Out-of-Network**: $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, any individual will not stop at their own out-of-pocket limits but will continue 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	$20 copay	50% 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	$20 copayment	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.
	Preventive care/screening/ immunization	No charge	50% 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)	10% 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.
	Imaging (CT/PET scans, MRIs)	10% 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.

* 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 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)	10% coinsurance	50% coinsurance after Deductible	Member Precertification may be required.
	Physician/surgeon fees	10% coinsurance	50% coinsurance after Deductible	-None-
If you need immediate medical attention	Emergency room care	10% coinsurance after Deductible	Covered as in-network benefit	Copayment waived if admitted
	Emergency medical transportation	10% coinsurance after Deductible	Covered as in-network benefit	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	In a physician's office: $20 copay After Hours Care Center: 10% coinsurance	In a physician's office: 50% coinsurance after Deductible After Hours Care Center: Not applicable	-None-
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after Deductible	50% 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	10% coinsurance after Deductible	50% 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 need mental health, behavioral	Outpatient services	10% coinsurance	50% coinsurance after Deductible	Member Precertification may be required. Failure to obtain precertification could result

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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)	
health, or substance abuse services				in up to 50% reduction in eligible expenses for each instance.
	Inpatient services	10% coinsurance after Deductible	50% 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	50% 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	50% 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	10% coinsurance after Deductible	50% coinsurance after Deductible	-None-
If you need help recovering or have other special health needs	Home health care	$20 copayment	50% coinsurance after Deductible	Maximum of 40 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	10% coinsurance	50% coinsurance after Deductible	Maximum of 30 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	10% coinsurance after Deductible	50% coinsurance after Deductible	Up to 60 visits per plan year. Member Precertification may be required. Failure to obtain precertification could result in covered person being responsible for the

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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)	
				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	10% coinsurance	50% 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

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

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-257-2753.

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

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

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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$1,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,621**

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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$50
Coinsurance	$186
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$791**

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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$60
Coinsurance	$178
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$738**

The plan would be responsible for the other costs of these EXAMPLE covered services.