This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.independenthealth.com. or by calling 1-800-501-3439.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1500** Single / **$3000** Family Applies to out-of-network benefits only	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services your plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. For non-participating providers. **$5000** Single / **$10,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copays, applicable pharmacy liability, balance-billed charges, penalty amounts, and non-covered services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.independenthealth.com or call 1-800-501-3439** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: $15 copay/visit Child: $45 copay/visit	30% coinsurance	---None---
	Specialist visit	Adult: $45 copay/visit Child: $45 copay/visit	30% coinsurance	---None---
	Other practitioner office visit	Chiropractor: $45 copay/visit; Allergy Injections: Adult: $15/$45 copay/visit Child: $45 copay/visit	30% coinsurance	---None---
	Preventive care/screening/immunization	No charge	Not Covered	All preventive services are covered in full with $0 member liability when performed by a participating provider. See independenthealth.com for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: $45 copay/visit; Blood work: No charge; EKG: Adult: $15/$45 copay/visit Child: $45 copay/visit	30% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	30% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans. Annual maximum copayment of $750. Authorization may be required

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.independenthealth.com.	Prescription Plan Tier 1 drugs	$7 with $0 Tier 1 for children	Not Covered	Must be filled at a participating Pharmacy Note: Insulin is a Tier 2 drug
	Prescription Plan Tier 2 drugs	$25	Not Covered	Must be filled at a participating Pharmacy Note: Insulin is a Tier 2 drug
	Prescription Plan Tier 3 drugs	$40	Not Covered	Must be filled at a participating Pharmacy Note: Insulin is a Tier 2 drug
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/visit	30% coinsurance	Authorization may be required
	Physician/surgeon fees	No charge	30% coinsurance	Authorization may be required
If you need immediate medical attention	Emergency room services	$200 copay/visit	$200 copay/visit	Waived if admitted
	Emergency medical transportation	$200 copay/trip	$200 copay/trip	Must be deemed medically necessary
	Urgent care	$75 copay/visit	Not Applicable	Coverage based on Participating After Hours Care Centers
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required
	Physician/surgeon fee	No charge	30% coinsurance	Authorization may be required
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Adults: $15 copay/visit Child: $25 copay/visit	30% coinsurance	Visit limitations may apply
	Mental/Behavioral health inpatient services	$250 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required Visit limitations may apply
	Substance use disorder outpatient services	Adults: $15 copay/visit Child: $25 copay/visit	30% coinsurance	Visit limitations may apply
	Substance use disorder inpatient services	$250 copay/admission	30% coinsurance	Semi-private room, per admission Authorization may be required Visit limitations may apply based on diagnosis

Common Medical Event	Services You May Need	Your cost If You Use an In-network Provider	Your cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	Adult: No charge Child: No charge	30% coinsurance	No charge after the initial diagnosis
	Delivery and all inpatient services	$250 copay/admission	30% coinsurance	Semi-private room, per admission
If you need help recovering or have other special health needs	Home health care	$45 copay/visit	30% coinsurance	Up to 40 visits per contract year Authorization may be required
	Rehabilitation services	$45 copay/visit	30% coinsurance	Up to 20 visits per contract year
	Habilitation services	$45 copay/visit	30% coinsurance	Up to 20 visits per contract year
	Skilled nursing care	$250 copay/admission	30% coinsurance	Semi-private room, per admission Up to 45 days per contract year Authorization may be required
	Durable medical equipment	20% coinsurance	50% coinsurance	$1000 maximum per contract year Authorization may be required
	Hospice service	No charge	30% coinsurance	---None---
If your child needs dental or eye care	Eye exam	$10 copay/visit	Not Covered	Once every 12 months
	Glasses	Single: $50 Bifocal: $70	Not Covered	Contact EyeMed for additional options at 1-877-842-3348
	Dental check up	Not Covered	Not Covered	---None---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S.
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care
- Infertility Treatment
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-501-3439. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact our Member Services Department at (716) 631-8701 or 1-800-501-3439 from 8:00am to 8:00pm, Monday through Friday. TDD users, please call (716) 631-3108.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $7,330**
- **Patient pays $210**

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$60
Co-insurance	$0
Limits or exclusions	$150
Total	**$210**

Managing type 2 diabetes
(a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $4,450**
- **Patient pays $950**

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$870
Co-insurance	$0
Limits or exclusions	$80
Total	**$950**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.