

Passport Plan Select

Coverage for: All Tier Levels | Plan Type: PPO



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, call 1-800-501-3439 or visit www.independenthealth.com. 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 www.independenthealth.com or call 1-800-501-3439 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$750 Individual / \$1500 Family Out-of-network: \$2,000 Individual / \$4,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> 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 deductible?	Yes, preventive care and other major categories of service, as identified in the SBC, are not subject to deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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</u> <u>limit</u> for this <u>plan</u> ?	For network providers \$3,000 Individual / \$6,000 Family; for out- of-network providers \$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 <u>plan</u> 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?	Premiums, 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.
Will you pay less if you use a network provider?	Yes. See www.independenthealth. com or call 1-800-501-3439 for a list of network providers.	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</u> charge 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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common	Services You May Need	What You	ı Will Pay		
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Primary care visit to treat an injury or illness	\$35 <u>copay</u> / visit	40% coinsurance	None Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
If you visit a health care provider's office or clinic	<u>Specialist</u> visit	\$50 <u>copay</u> / visit	40% coinsurance	None Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Preventive care/screening/immunization	No charge	40% coinsurance	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. Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	<u>Diagnostic test</u> (x-ray, blood work)	X-ray: \$15 <u>copay</u> / visit; Blood work: \$0 <u>copay</u> / visit; EKG: 10% <u>coinsurance</u>	40% coinsurance	None Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Imaging (CT/PET scans, MRIs)	\$15 <u>copay</u> / visit	40% coinsurance	Radiology services, other than X-rays, including but not limited to MRI, MRA, CT Scans, myocardial perfusion imaging and PET Scans.	

Common	Services You May Need	What You	ı Will Pay		
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need drugs to treat your illness or condition	Preferred Generic Drugs (Tier 1)	\$15	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.	
More information about prescription drug coverage is available	Non-Preferred Generic Drugs (Tier 2)	\$30	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.	
at www.independenthealt h.com	Non-Preferred Brand Name Drugs (Tier 3)	\$60	Not Covered	Mail Order: Must be obtained from ProAct or Wegmans. Retail Pharmacy: Must be filled at a participating Pharmacy.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	40% coinsurance	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Emergency room care	\$100 <u>copay</u> / visit	\$100 <u>copay</u> / visit	Copay waived if admitted	
If you need immediate medical attention	Emergency medical transportation	\$100 <u>copay</u> / trip	\$100 <u>copay</u> / trip	Must be deemed medically necessary	
	Urgent care	\$75 copay / visit	\$75 copay / visit	None	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Physician/surgeon fees	10% coinsurance	40% coinsurance	None Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	

Common	Services You May Need	What You Will Pay			
Medical Event		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need mental health, behavioral	Outpatient services	\$0 <u>copay</u> / visit	40% coinsurance	None Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
health, or substance abuse services	Inpatient services	10% coinsurance	instance. Semi-private room, per adm Authorization may be requir obtain could result in a pena 50% reduction in covered sinstance. No charge after the initial di	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
If you are pregnant	Office visits	\$0 copay / visit	40% coinsurance	No charge after the initial diagnosis. Provided in accordance with USPSTF and HRSA guidelines	
	Childbirth/delivery professional services	Physician: 10% coinsurance	40% coinsurance	Semi-private room, per admission Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Childbirth/delivery facility services	Delivery: 10% coinsurance	40% coinsurance	Semi-private room, per admission	

Common Medical Event	Services You May Need	What You Will Pay			
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Home health care	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Up to 40 visits per contract year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Rehabilitation services	10% coinsurance	40% coinsurance	Up to 20 visits per contract year combined	
	<u>Habilitation services</u>	10% coinsurance	40% coinsurance	None	
If you need help recovering or have other special health needs	Skilled nursing care	10% coinsurance	40% coinsurance	Semi-private room, per admission Up to 45 days per contract year Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Durable medical equipment	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Authorization may be required. Failure to obtain could result in a penalty of up to a 50% reduction in covered services per instance.	
	Hospice services	\$0 copay / admission	40% coinsurance	None	
If your child needs dental or eye care	Children's eye exam	\$0 copay / visit	Not Covered	Once every 12 months	
	Children's glasses	Single: \$50 Bifocal: \$70	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:

Acupuncture

Long-Term Care

Routine Eye Care (Adult)

Cosmetic Surgery

- Non-Emergency Care When Traveling Outside the U.S.
- Routine Foot Care

Dental Care (Adult)

Private-Duty Nursing

Weight Loss Programs

Hearing Aids

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric Surgery

Chiropractic Care

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, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, the Department of Health Insurance Oversight, at 1-877-267-2323 x61565 or www.dol.gov/ebsa/healthreform, on the Department of Health Insurance Oversight (www.dol.gov/ebsa/healthreform). The Department of Health Insurance Oversight (www.dol.gov/ebsa/healthreform) and the Department of Health Insurance Oversight (www.dol.gov/ebsa/healthreform). The Department of Health Insurance Oversight (www.dol.gov/ebsa/healthreform) and the Department of Health Insurance Oversight (www.dol.gov/ebsa/healthreform). The Department of Health Insurance Oversight (

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>. Additionally, a consumer assistance program can help you file your <u>appeal</u>. 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 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:

Please refer to Nondiscrimination statement and language assistance services contained within.

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

About these Coverage Examples:

What isn't covered

\$60

\$1910

Limits or exclusions

The total Joe would pay is

Limits or exclusions

The total Peg would pay is



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

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Peg is Having a Baby (9 months of in-network pre-natal ca hospital delivery)	e and a	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> Other <u>copayment</u> 	\$750 \$50 10% \$50	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copayment</u> Hospital (facility) <u>copayment</u> Other <u>copayment</u> 	\$750 \$50 10% \$50	 The plan's overall deductible Specialist copayment Hospital (facility) copayment Other copayment 	\$750 \$50 10% \$50
This EXAMPLE event includes services lile Specialist office visits (prenatal care) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (ultrasounds and blood we Specialist visit (anesthesia)		This EXAMPLE event includes service Primary care physician office visits (includes as education) Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose in	cluding	This EXAMPLE event includes services Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches) Rehabilitation services (physical therap)	al
Total Example Cost	\$12700	Total Example Cost	\$7400	Total Example Cost	\$1900
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$700	Deductibles	\$700	Deductibles	\$700
Copayments	\$50	Copayments	\$200	Copayments	\$200
Coinsurance	\$1100	Coinsurance	\$0	Coinsurance	\$40
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Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Independent Health Member Services at 1-800-501-3439.

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

What isn't covered

\$60

\$960

Limits or exclusions

The total Mia would pay is

\$0

\$940

What isn't covered

Nondiscrimination statement and language assistance services

If you, or someone you're helping, have questions about Independent Health, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-501-3439.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independent Health, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-501-3439.

如果您,或是您正在協助的對象,有關於[插入Independent Health 項目的名稱Independent Health 方面的問題,您 有權利免費以您的母語得到幫助和訊息。 洽詢一位翻譯員,請撥電話「在此插入數字1-800-501-3439。

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Independent Health, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-501-3439.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Independent Health, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-800-501-3439.

만약귀하또는귀하가돕고있는어떤사람이Independent Health 에관해서질문이있다면귀하는그러한 도움과정보를귀하의언어로비용부담없이얻을수있는권리가 있습니다. 그렇게통역사와얘기하기위해서는 1-800-501-3439 로전화하십시오.

Se tu o qualcuno che stai aiutando avete domande su Independent Health, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-800-501-3439.

אויב איר. אודר עמצער איר העלפסט, האט פראגעס וועגן, Independent Health איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך אומזיסט. צו רעדן מיט דער אי'בערזעצר, קלונג 1-800-501-3439

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, সম্পর্কে প্রশ্ন আছে Independent Health অধিকার আছে বিনা থরচে আপনার নিজয় ভাষাতে সাহায্য পাবার এবং ভখ্য জানবার। অনুবাদকের সাথে কখা বলার জন্য, কল করুন 1-800-501-3739

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Independent Health, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-800-501-3439.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Independent Health ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 3439-501-508

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Independent Health, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-800-501-3439.

Independent Health.

اگر آپ کسی کو مدد دے رہے ہیں اور آپ دونوں کو سوال ہے۔ Independent Health کے بارے میں، تو آپ دونوں کو اپنی زبان میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 3439-501-800-1 فون کریں۔

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Independent Health, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap angisang tagasalin, tumawag sa 1-800-501-3439.

Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Independent Health, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 1-800-501-3439.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Independent Health, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-800-501-3439.

Discrimination is Against the Law

Independent Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independent Health does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independent Health:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - O Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - o Qualified interpreters
 - o Information written in other languages

If you need these services, contact Independent Health's Member Services Department.

If you believe that Independent Health has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Independent Health's Member Services Department, 511 Farber Lakes Drive, Buffalo, NY 14221, 1-800-501-3439, TTY users call 1-800-432-1110, fax (716) 635-3504, memberservice@servicing.independenthealth.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Independent Health's Member Services Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html

