




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: \$1,000 Individual / \$2,000 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: \$5,000 Individual / \$10,000 Family Out-of-Network: \$5,000 Individual / \$10,000 Family Pharmacy: \$1,600 Individual / \$3,200 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 |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| | | 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: \$10 copayment Child: \$20 copayment | 20% coinsurance | 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 | 20% coinsurance | 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 | 20% 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. **Routine Physicals and Immunizations are not covered out of network. |
| If you have a test | Diagnostic test (x-ray, blood work) | X-Ray: \$20 copayment Laboratory: No charge | 20% coinsurance | 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) | \$20 copayment | 20% coinsurance | 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 | Generic drugs | \$5 Copay – Retail | Not covered. | Must be filled at a participating pharmacy. |

| 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) | |
| treat your illness or condition More information about prescription drug coverage is available at www.pbdrx.com | | \$10 Copay – Mail order | | |
| | Preferred brand drugs | \$25 Copay – Retail \$50 Copay – Mail order | Not covered. | Must be filled at a participating pharmacy. |
| | Non-preferred brand drugs | \$50 Copay – Retail \$100 Copay – Mail order | Not covered. | Must be filled at a participating pharmacy. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$75 copayment | 20% coinsurance | 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 | 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 | Emergency room care | \$40 copayment | \$40 copayment | Copayment waived if admitted |
| | Emergency medical transportation | \$25 copayment | \$25 copayment | Must be deemed medically necessary. Wheelchair van transportation is not covered |
| | Urgent care | \$35 copayment | \$35 copayment | -None- |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 20% coinsurance | 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 | 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 mental | Outpatient services | \$15 copayment | 20% coinsurance | -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) | |
| health, behavioral health, or substance abuse services | Inpatient services | No charge | 20% coinsurance | Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance |
| If you are pregnant | Office visits | No charge after initial diagnosis | 20% coinsurance | 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 | 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 | 20% coinsurance | 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 help recovering or have other special health needs | Home health care | \$20 copayment | 20% coinsurance | 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 |
| | Rehabilitation services | \$20 copayment | 20% coinsurance | Up to 20 visits per plan year (combined). |
| | Habilitation services | Not covered | Not covered | -None- |
| | Skilled nursing care | No charge | 20% coinsurance | Up to 45 days 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. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses |

| 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) | |
| | Hospice services | No charge | 20% coinsurance | for each instance. Hospice services shall include supplies & drugs. |
| If your child needs dental or eye care | Children's eye exam | \$10 copayment | Not covered. | Once every 12 months |
| | Children's glasses | Single vision: \$50 Bifocal: \$70 Trifocal: \$105 Progressive: \$135 Frames: 40% off retail | Not covered. | Contact EyeMed for additional options at 1-877-842-3348 |
| | Children's dental check-up | Not covered. | Not covered. | |

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 .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery | <ul style="list-style-type: none"> Dental Care (Adult) Hearing aids Long-Term care | <ul style="list-style-type: none"> Non-Emergency care when traveling outside the US Private duty nursing Weight loss programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) | | |
| <ul style="list-style-type: none"> Chiropractic Care Infertility treatment | <ul style="list-style-type: none"> Routine eye care (Adult) 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: For more information on your rights to continue coverage, contact Kathy Kightlinger at 716-874-8400 ext 20348. 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): 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.

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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 [cost sharing] | \$20 |
| ■ Hospital (facility) [cost sharing] | \$0 |
| ■ Other [cost sharing] | 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$50 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$110 |

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 [cost sharing] | \$20 |
| ■ Hospital (facility) [cost sharing] | \$0 |
| ■ Other [cost sharing] | 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$655 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|------|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist [cost sharing] | \$20 |
| ■ Hospital (facility) [cost sharing] | \$0 |
| ■ Other [cost sharing] | 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$225 |
| Coinsurance | \$7 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$232 |

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