



Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Kenmore-Town of Tonawanda: First Choice HDHP

Coverage Period:
Coverage for: 7/1/2020 – 6/30/2021 | Plan Type: HDHP




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 & Out of Network: \$1,400 Individual/ \$2,800 Family for All Tiers (First Choice Tier 1, Specialty Services, Non-First Choice Facilities, Par Physician and Ancillary (IHC Network) & Out-of-Network).	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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
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>?	Medical In-Network & Out of Network: \$6,900 Individual/ \$13,900 Family for All Tiers. Pharmacy: \$1,600 Individual/ \$3,200 Family for All Tiers	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> , the overall family <u>out-of-pocket limit</u> must be 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

		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 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	First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	Limitations, Exceptions, & Other Important Information
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Deductible then \$20	N/A	N/A	Adult: Deductible then \$10 Child: Deductible then \$20	Deductible then 30%	If you receive a blood or specimen draw during your office visit, you are responsible for the office visit copay only. 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.
	<u>Specialist</u> visit	Deductible \$20 copay	N/A	N/A	Deductible then \$20	Deductible then 30%	If you receive a blood or specimen draw during your office visit, you are responsible for the office visit copay only. Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	No charge	No charge	Not covered	If you receive a blood or specimen draw during your office visit, you are responsible for the office visit copay only. You may have to pay for services

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

Common Medical Event	Services You May Need	First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	Limitations, Exceptions, & Other Important Information
							that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-Ray: Deductible then Covered in full Blood work: Deductible then Covered in full	X-Ray: Deductible then \$20 Blood work: Deductible then Covered in full	X-Ray: Deductible then 30% Blood work: Deductible then 30%	X-Ray: Deductible then \$10 PCP/ \$20 SCP Blood work: Deductible then 30%	Deductible then 30%	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)	Deductible then Covered in full	Deductible then \$20	Deductible then 30%	Deductible then \$20	Deductible then 30%	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 treat your illness or condition More information about <u>prescription drug coverage</u> is available at FirstChoiceBuffalo.org	Generic drugs/ Tier 1	N/A	N/A	N/A	Deductible then \$5 - Retail Deductible then \$12.50-Mail Order	N/A	Must be filled at a participating pharmacy.
	Preferred brand drugs/ Tier 2	N/A	N/A	N/A	Deductible then \$25- Retail Deductible then \$62.50-Mail Order	N/A	Must be filled at a participating pharmacy.
	Non-preferred brand drugs/ Tier 3	N/A	N/A	N/A	Deductible then \$50- Retail Deductible then \$125-Mail Order	N/A	Must be filled at a participating pharmacy.

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Common Medical Event	Services You May Need	First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible then Covered in full	Deductible then \$75	Deductible then 30%	N/A	Deductible then 30%	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	N/A	N/A	N/A	Covered in full	Deductible then 30%	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	Deductible then \$250	Deductible then \$250	Deductible then \$250	N/A	Covered as in-network benefit	Copayment waived if admitted
	Emergency medical transportation	N/A	N/A	N/A	Deductible then \$100	Covered as in-network benefit	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	N/A	N/A	N/A	Deductible then \$50	Covered as in-network benefit	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible then Covered in full*	Deductible then \$250*	Deductible then 30% coinsurance*	N/A	Deductible then 30%	*If admitted through ER, Covered in Full. 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	N/A	N/A	N/A	Deductible then covered in full	Deductible then 30%	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	First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: Deductible then \$10 Child: Deductible then \$20	Adult: Deductible then \$10 Child: Deductible then \$20	Deductible then 30%	Adult: Deductible then \$10 Child: Deductible then \$20	Deductible then 30%	--None--
	Inpatient services	Deductible then covered in full	Deductible then \$250*	Deductible then 30%*	N/A	Deductible then 30%	*If admitted through ER, Covered in Full. 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	N/A	N/A	N/A	Covered in full after initial diagnosis	Deductible then 30%	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	N/A	N/A	N/A	Deductible then Covered in full	Deductible then 30%	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	Deductible then Covered in full	Deductible then 30%	Deductible then 30%	N/A	Deductible then 30%	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	Erie & Niagara County: Deductible then Covered in full	N/A	Erie & Niagara County: Deductible then 30% All other WNY Counties: Deductible then	Deductible then \$20	Deductible then 30%	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	First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	Limitations, Exceptions, & Other Important Information
				\$20			
	Rehabilitation services	Deductible then Covered in full	Deductible then \$20	Deductible then 30%	Deductible then \$20	Deductible then 30%	Up to 20 visits per plan year (combined).
	Habilitation services	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	--None--
	Skilled nursing care	Deductible then Covered in full*	Deductible then \$250**	Deductible then 30%**	N/A	Deductible then 30%	*Up to 90 days per plan year. **Up to 45 days per plan year which counts toward the 90 day limit. 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	N/A	N/A	N/A	Deductible then 20%	Deductible then 50%	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Hospice services	Deductible then Covered in full	Deductible then covered in full	Deductible then covered in full	N/A	Deductible then 30%	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	N/A	N/A	N/A	N/A	N/A	Covered by EyeMed. 1-877-842-3348
	Children's glasses	N/A	N/A	N/A	N/A	N/A	Contact EyeMed for additional options at 1-877-842-3348
	Children's dental check-up	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	--None--

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

Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <u>excluded services</u> .)		
• Acupuncture	• Dental care (Adult)	• Non-Emergency care when traveling outside the US
• Bariatric Surgery	• Hearing aids	• Private-duty nursing
• Cosmetic Surgery	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
• Chiropractic Care	• Routine eye care (Adult)	
• Infertility treatment	• Routine foot care	

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact Kathy Kightlinger at 716-874-8400 ext 20348. 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 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. Additionally, a consumer assistance program can help you file your appeal. 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**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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](#) \$1,400
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 30%

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	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$40
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$1,500

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 30%

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	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$925
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$2,380

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,400
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 30%

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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,400
Copayments	\$360
Coinsurance	\$7
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,767