Independent Health

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period:

Kenmore-Town of Tonawanda: First Choice HDHP

Coverage for: 7/1/2019 – 6/30/2020 | **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 deductible?	**In-Network & Out of Network: $1,350** Individual/ **$2,700** 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 providers up to the deductible amount before the plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	**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 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?	**Medical In-Network & Out of Network:** $5,000 Individual/ $10,000 Family for All Tiers. **Pharmacy: $1,600** Individual/ **$3,200** Family for All Tiers	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, the overall family out-of-pocket limit must be 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	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 provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay	N/A	N/A	Adult: $10 copay Child: $20 copay	30% coinsurance	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.
	Specialist visit	$20 copay	N/A	N/A	$20 copay	30% coinsurance	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.
	Preventive care/screening/ immunization	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

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							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	Diagnostic test (x-ray, blood work)	X-Ray: Covered in full Blood work: Covered in full	X-Ray: $20 copay Blood work: Covered in full	X-Ray: 30% coinsurance Blood work: 30% coinsurance	X-Ray: $10 PCP/ $20 copay SCP Blood work: 30% coinsurance	30% 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)	Covered in full	$20 copay	30% coinsurance	$20 copay	30% 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 treat your illness or condition More information about prescription drug coverage is available at FirstChoiceBuffalo.org	Generic drugs/ Tier 1	N/A	N/A	N/A	$5 copay*-Retail $12.50*-Mail Order	N/A	*Deductible applies. Must be filled at a participating pharmacy.
	Preferred brand drugs/ Tier 2	N/A	N/A	N/A	$25 copay*-Retail $62.50*-Mail Order	N/A	*Deductible applies. Must be filled at a participating pharmacy.
	Non-preferred brand drugs/ Tier 3	N/A	N/A	N/A	$50 copay*-Retail $125*-Mail Order	N/A	*Deductible applies. Must be filled at a participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Covered in full	$75 copay	30% coinsurance	N/A	30% 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	N/A	N/A	N/A	Covered in full	30% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible

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

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							expenses for each instance.
If you need immediate medical attention	Emergency room care	$250 copay	$250 copay	$250 copay	N/A	$250 copay	Copayment waived if admitted
	Emergency medical transportation	N/A	N/A	N/A	$100 copay	$100 copay	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	N/A	N/A	N/A	$35 copay	$35 copay	Participating After Hours Urgent Care coverage
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full*	$250 copay*	30% coinsurance*	N/A	30% coinsurance*	*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	Covered in full	30% 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 health, behavioral health, or substance abuse services	Outpatient services	Adult: $10 copay Child: $20 copay	Adult: $10 copay Child: $20 copay	30% coinsurance	Adult: $10 copay Child: $20 copay	30% coinsurance	--None--
	Inpatient services	Covered in full	$250 copay*	30% coinsurance*	N/A	30% coinsurance	*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	30% 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	N/A	N/A	N/A	Covered in full	30%	Member Precertification may be

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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
	professional services					coinsurance	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	Covered in full	30% coinsurance	30% coinsurance	N/A	30% 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	**Erie & Niagara County:** Covered in full	N/A	**Erie & Niagara County:** 30% coinsurance **All other WNY Counties:** $20 copay	$20 copay	30% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.
	Rehabilitation services	Covered in full	$20 copay	30% coinsurance	$20 copay	30% coinsurance	Up to 20 visits per plan year (combined).
	Habilitation services	Not covered.	Not covered.	Not covered.	Not covered.	Not covered.	--None--
	Skilled nursing care	Covered in full*	$250 copay**	30% coinsurance**	N/A	30% coinsurance **	*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	20% coinsurance	50% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible expenses for each instance.

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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
	Hospice services	Covered in full	Covered in full	Covered in full	N/A	30% coinsurance	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--

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	• 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 plan 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/

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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, 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.

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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	$1,350
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

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

The plan's overall deductible	$1,350
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$680
Coinsurance	$0
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,085**

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

The plan's overall deductible	$1,350
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$360
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,717**

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