




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 for First Choice Tier 1 and Specialty Services. Out of Network: \$2,000 Individual / \$4,000 Family for 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 <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 & Out of Network: \$5,000 Individual/ \$10,000 Family for First Choice Providers, Specialty Services, Non-First Choice Facility, Par Physician and Ancillary (IHC Network) or Out-of-Network providers	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 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	\$20 copay	N/A	N/A	Adult: \$10 copay Child: \$20 copay	20% 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.
	<u>Specialist</u> visit	\$20 copay	N/A	N/A	\$20 copay	20% 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.
	<u>Preventive care/screening/</u>	No charge	No charge	No charge	No charge	Not covered	If you receive a blood or specimen draw

* 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
	immunization						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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	X-Ray: \$20 copay Blood work: Covered in full	X-Ray: \$20 copay Blood work: Covered in full	X-Ray: 20% coinsurance Blood work: 20% coinsurance	X-Ray: \$20 copay Blood work: 20% coinsurance	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 copay	\$20 copay	20% coinsurance	\$20 copay	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 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	\$5 copay-Retail \$12.50-Mail Order	N/A	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	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	Must be filled at a participating pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 copay	\$125 copay	20% coinsurance	N/A	20% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to 50% reduction in eligible

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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
							expenses for each instance.
	Physician/surgeon fees	N/A	N/A	N/A	Covered in full	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	\$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	\$50 copay	\$50 copay	Participating After Hours Urgent Care Coverage
If you have a hospital stay	Facility fee (e.g., hospital room)	Covered in full	\$500 copay*	20% coinsurance*	N/A	20% 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	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 health, behavioral health, or substance abuse services	Outpatient services	Adult: \$10 copay Child: \$20 copay	Adult: \$10 copay Child: \$20 copay	20% coinsurance	Adult: \$10 copay Child: \$20 copay	20% coinsurance	--None--
	Inpatient services	Covered in full	\$500 copay	20% coinsurance	N/A	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	N/A	N/A	N/A	Covered in full after initial diagnosis	20% coinsurance	Cost sharing does not apply for preventative services. If a visit is unrelated to Pregnancy,

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
							member liability may apply based on services rendered.
	Childbirth/delivery professional services	N/A	N/A	N/A	Covered in full	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	Covered in full	20% coinsurance	20% coinsurance	N/A	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	Erie & Niagara County: \$20 copay	N/A	Erie & Niagara County: 20% coinsurance All other WNY Counties: \$20 copay	\$20 copay	20% 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	\$20 copay	\$20 copay	20% coinsurance	\$20 copay	20% 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*	\$500 copay**	20% coinsurance**	N/A	20% 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.

* 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
	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.
	Hospice services	Covered in full	Covered in full	Covered in full	N/A	20% 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	• Hearing aids	• Private-duty nursing
• Cosmetic Surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Non-Emergency care when traveling outside the US	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Chiropractic care	• Routine eye care (Adult)	

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](#) \$2,000
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 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	\$12,731
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$120

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 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	\$7,389
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$680
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$735

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

- The [plan's](#) overall [deductible](#) \$2,000
- [Specialist](#) copayment \$20
- Hospital (facility) copayment \$0
- Other [coinsurance](#) 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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,190
Coinsurance	\$7
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,197