Kenmore - Town of Tonawanda Union Free School District
First Choice Health Plan
Benefit Comparison Summary

First Choice	First Choice Flex Health Plan Out-of-Pocket Max. $5,000 individual $10,000 family Prescription Drug (Rx) Out of Pocket Max. $1,600 individual $3,200 family	Non-First Choice Providers Out-of-Network Providers $2,000 Individual Deductible / $4,000 Family Deductible Deductible must be met before 20% benefit is paid $5,000 individual out-of-pocket max $10,000 family out-of-pocket max	Explanations and Limitations	First Choice High Deductible Health Out-of-Pocket Max. $5,000 individual $10,000 family Prescription Drug (Rx) Out of Pocket Max. $1,600 individual $3,200 family	Non-First Choice Providers and Out-of-Network Providers $1,250 Individual Deductible / $2,500 Family Deductible Combined In and Out of Network Deductible must be met before 30% benefit is paid $5,000 individual out-of-pocket max $10,000 family out-of-pocket max	Explanations and Limitations
Hospital Services provided by First Choice Preferred Provider Network (PPN)						
Medical Services						
Radiology, Ultrasounds	$20 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Laboratory Testing	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
MRI and CAT scans	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	Pre-cerification is required.	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Pre-certification is required.
Women's Services						
Mammograms	$0 co-pay	IH Provider - $0 co-pay Out-of Network Providers - 20% after $2,000 individual or $4,000 family deductible	Limited to the following: Age 35-39: one baseline; age 40-49: one mammogram up to once every two years, or more frequently upon the recommendation of a physician; age 50 and older: one mammogram in each calendar year.	$0 co-pay	IH Provider - $0 co-pay Out-of Network Providers - 30% after $1,250 individual or $2,500 family deductible	Limited to the following: Age 35-39: one baseline; age 40-49: one mammogram up to once every two years, or more frequently upon the recommendation of a physician; age 50 and older: one mammogram in each calendar year.
Hospital Care						
Inpatient Stay-Semi Private Room	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Additional In-Network Services $500 ($1,000 annual max.) co-pay applies: 1. Roswell Park Cancer Institute: cancer treatment 2.Women & Children's Hospital: pediatrics 3. ECMC: burn treatment, transplants, trauma, mental health/substance abuse 4. BryLyn Behavioral Health System: mental health/substance abuse Pre-certification is required. All other out of network providers subject to deductible and coinsurance	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Additional In-Network Services $250 ($500 annual max.) co-pay applies: 1. Roswell Park Cancer Institute: cancer treatment 2.Women & Children's Hospital: pediatrics 3. ECMC: burn treatment, transplants, trauma, mental health/substance abuse 4. BryLyn Behavioral Health System: mental health/substance abuse Pre-certification is required. All other out of network providers subject to deductible and coinsurance

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Anesthesia	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Assistant Surgeon	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Services rendered by an Out-of-Network provider will be reimbursed at the In-Network benefit level when related services are In-Network	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Services rendered by an Out-of-Network provider will be reimbursed at the In-Network benefit level when related services are In-Network
Hospital Physician Visits (Non-Mental Illness, Non-Substance Abuse Diagnosis)	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Visits by an out-of-network physician are limited to one per day per condition. Consultants by an out-of-network physician are limited to two consultations during a single inpatient confinement. Out-of-Network services will be reimbursed at the In-Network benefit when related services are In-Network	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Visits by an out-of-network physician are limited to one per day per condition. Consultants by an out-of-network physician are limited to two consultations during a single inpatient confinement. Out-of-Network services will be reimbursed at the In-Network benefit when related services are In-Network
Organ Transplants	$500 individual / $1,000 family co-pay	20% after $2,000 individual or $4,000 family deductible	Specialty in-network service when performed at Erie County Medical Center	$250 individual / $500 family co-pay	30% after $1,250 individual or $2,500 family deductible	Specialty in-network service when performed at Erie County Medical Center
Surgical Expenses - Surgeon	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Blood, Blood Plasma & Oxygen	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions when performed at a participating facility where related surgery will be performed	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Blood and/or plasma, if not replaced, and the equipment for its administration including autologous blood transfusions when performed at a participating facility where related surgery will be performed
Outpatient Eye Surgery Facility	$0 co-pay	Independent Health Provider Network: $125 co-pay; out-of-network - 20% after $2,000 individual or $4,000 family deductible		Independent Health Provider Network: $75 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	

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Outpatient Surgery Facility	$125 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	$75 co-pay after $1,250 individual or $2,500 family deductible for services provided by additional in-network service providers
Chemotherapy, Radiation Therapy, Inhalation Therapy	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	$20 co-pay for services provided by Roswell Park Cancer Institute	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	$20 co-pay after $1,250 individual or $2,500 family deductible for services provided by Roswell Park Cancer Institute
Cardiac Rehabilitation	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Limited 36 visits per member, per plan year	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Limited to 36 visits per member, per plan year.
Occupational, Speech, Physical Therapy	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	Limited to 20 aggregate visits, per member, per plan year	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Limited to 20 aggregate visits, per member, per plan year.
Emergency Room Visit	$250 co-pay	$250 co-pay	Co-pay waived if admitted to hospital. Must be medically necessary.	$250 co-pay after $1,250 individual or $2,500 family deductible	$250 co-pay after $1,250 individual or $2,500 family deductible	Co-pay waived if admitted to hospital. Must be medically necessary.
Emergency Ambulance	$100 co-pay	$100 co-pay	When medically necessary. Wheelchair van transportation is not covered	$100 co-pay after $1,250 individual or $2,500 family deductible	$100 co-pay after $1,250 individual or $2,500 family deductible	When medically necessary. Wheelchair van transportation is not covered
Other Hospital Services						
Home Health Care	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	40 visits per plan year Professional Home Health care is not available for Pediatrics or mental health All Home Health Care visits must be pre authorized in and out of network visits	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	40 visits per plan year Professional Home Health care is not available for Pediatrics or mental health All Home Health Care visits must be pre-authorized in and out of network visits
Hospice	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Bereavement counseling is available to family members either before or after death. Unlimited days	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Bereavement counseling is available to family members either before or after death. Unlimited days
Private Duty Nursing	Not covered	Not Covered		Not Covered	Not Covered	

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Skilled Nursing Facility Non-Custodial	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	Pre-certification is required. 90 days maximum. Custodial care not covered	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Pre-certification is required. 90 days maximum. Custodial care not covered

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Physician and Ancillary Services Provided by the Independent Health Provider Network						
Medical Services						
Primary Care Physician Visits	Adult: $10 co-pay Child: $20 co-pay	20% after $2,000 individual or $4,000 family deductible		Adult: $10 co-pay Child: $20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Routine Physicals	$0 co-pay	Not Covered		$0 co-pay	Not Covered	
Well Child Visits and Immunizations (to age 19)	$0 co-pay	Not Covered	All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Covered Immunizations are as follows: Diphtheria; pertussis; tetanus; polio; measles; rubella; mumps; hemophilus influenza	$0 co-pay	Not Covered	All well child visits must be provided in accordance with the standards and frequency schedule of the American Academy of Pediatrics. Covered Immunizations are as follows: Diphtheria; pertussis; tetanus; polio; measles; rubella; mumps; hemophilus influenza
Allergy Testing & Injections	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	Co-pay does not apply to the allergy serum	Adult: $10 co-pay Child: $20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Co-pay does not apply to the allergy serum
Chiropractic Care	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	Maintenance care is not covered.	$20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Maintenance care is not covered.
Specialist Visits	$20 co-pay	20% after $2,000 individual or $4,000 family deductible	No referrals necessary.	$20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Second Surgical Opinion	$20 co-pay	20% after $2,000 individual or $4,000 family deductible		$20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	

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Women's Services						
Maternity Care (pre-natal and post-natal care)	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Routine Gynecological office visits	$0 co-pay	Not Covered	Limited to one per calendar year for women 18 years or older.	$0 co-pay	Not Covered	
Pap Smear	$0 co-pay	Not Covered	Limited to one per calendar year for women 18 years or older.	$0 co-pay	Not Covered	
* Subject to change when additional providers are added to the First Choice Network * *Out-of-network- a provider that is not the First Choice Network or not participating with Independent Health within the eight counties of Western New York						
Mental Health Care						
Inpatient	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	$500 ($1,000 annual max.) applies for services rendered at ECMC and BryLin Behavior Health System	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	$250 ($500 annual max.) applies for services rendered at ECMC and BryLin Behavioral Health System
Hospital Physician Visits (Mental Illness Diagnosis)	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Outpatient †Biological Based Mental Illness	Adult: $10 co-pay Child: $20 co-pay	20% after $2,000 individual or $4,000 family deductible		Adult: $10 co-pay Child: $20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Substance Abuse Treatment						
Inpatient	$0 co-pay	20% after $2,000 individual or $4,000 family deductible	$500 ($1,000 annual max.) applies for services rendered at ECMC and BryLin Behavior Health System	$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	$250 ($500 annual max.) applies for services rendered at ECMC and BryLin Behavioral Health System
Hospital Physician Visits (Alcohol Substance Abuse Diagnosis)	$0 co-pay	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible		$250 ($500 annual max.) applies for services rendered at ECMC and BryLin Behavioral Health System
Outpatient	Adult: $10 co-pay Child: $20 co-pay	20% after $2,000 individual or $4,000 family deductible	Family therapy visits may only be used by family members who are covered under the Plan	Adult: $10 co-pay Child: $20 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	Family therapy visits may only be used by family members who are covered under the Plan.
Other Physician/Ancillary Services						
Durable medical equipment	20% coinsurance	50% after $2,000 individual or $4,000 family deductible	Pre-certification is required.	20% co-pay after $1,250 individual or $2,500 family deductible	50% after $1,250 individual or $2,500 family deductible	Pre-certification is required.

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Urgent Care Center	$50 co-pay	IH Provider - $75 co-pay Out-of Network Providers - 20% after $2,000 individual or $4,000 family deductible		$35 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	
Prosthetic Devices	20% coinsurance	50% after $2,000 individual or $4,000 family deductible	Pre-certification is required.	20% coinsurance after $1,250 individual or $2,500 family deductible	50% after $1,250 individual or $2,500 family deductible	Pre-certification is required.
†Biological based mental illness is defined as: a mental or nervous or emotional condition that is caused by a biological disorder of the brain and results in a clinically significant, psychological syndrome or pattern that substantially limits the function						
hen additional providers are added to the First Choice Network						
Out-of-network- a provider does not participate in the First Choice Network or not participating with Independent Health within the 8 counties of WNY						
Vision Care						
Vision exam for each family member	$0 co-pay	Not Covered	Limited to one routine eye examination per calendar year when using a participating network provider	$0 co-pay after $1,250 individual or $2,500 family deductible	Not Covered	Annual - children under age 14 with diagnosed refractive error; bi-annual otherwise.
Prescription Benefits						
Generic Formulary/ Brand Formulary/ Non-Formulary	$5/$25/$50 All Prescriptions paid under First Choice Prescription Drug Plan Administered by Independent Health's Pharmacy Benefit Dimensions	Not Covered	First Choice Prescription Drug Plan is administered by Independent Health Pharmacy Benefit Dimensions. Mail order co-pay per 90 supply: $12.50/$62.50/$125	$5/$25/$50 after $1,250 individual or $2,500 family deductible All prescriptions paid under First Choice Prescription Drug Plan Administered by Independent Health's Pharmacy Benefit Dimensions	Not Covered	No co-pay for diabetic supplies. First Choice Prescription Drug Plan is administered by Independent Health Pharmacy Benefit Dimensions. Mail order co-pay per 90 supply: $12.50/$62.50/$125 after $1,250 individual or $2,500 family deductible
Diabetic supplies and equipment	$0 Paid under First Choice Prescription Drug Plan at any Independent Health Network Provider	20% after $2,000 individual or $4,000 family deductible		$0 co-pay after $1,250 individual or $2,500 family deductible	30% after $1,250 individual or $2,500 family deductible	

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Dependent Coverage						
Dependent/Student coverage to age (if ineligible for another employer sponsored health plan)	26			26		
Deductible / Coinsurance / Out-of-Pocket Maximum						
Deductible	Not applicable	$2,000 Individual / $4,000 Family		Not applicable	$1,250 Individual / $2,500 Family Deductible	
Coinsurance after deductible	Not applicable	20%		Not applicable	30%	
Health: Out-of-pocket maximum	$5,000 individual / $10,000 family	$5,000 individual / $10,000 family		$5,000 individual / $10,000 family	$5,000 individual / $10,000 family	
Prescription Drug: Out-of-pocket maximum	$1,600 individual / $3,200 family	Not applicable		$1,600 indvidual / $3,200 family	Not applicable	

Subject to change when additional providers are added to the First Choice Network

Out-of-network- a provider does not participate in the First Choice Network or not participating with Independent Health within the eight counties of Western New York

This summary represents a brief overview of benefits provided by the First Choice Health Plan. Plan specific information is detailed within the Plan Document. In the event of a discrepancy between this summary and the Plan Document, the Plan Document will prevail.