Independent Health

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

**Kenmore-Town of Tonawanda: Family Plan**

**Coverage Period:**
**Coverage for:** 7/1/2018 – 6/30/2019 | **Plan Type:** POS

**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**: $0<br>**Out-of-Network**: $500 Individual / $1,000 Family | 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| **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?** | **In-Network**: $5,000 Individual / $10,000 Family<br>**Out-of-Network**: $2,500 Individual / $5,000 Family<br>**Pharmacy**: $1,600 Individual / $3,200 Family | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been 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 | 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: $15 copayment<br>Child: 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. 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 | Not covered. | 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** | Diagnostic test (x-ray, blood work) | X-Ray: $20 copayment<br>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. |

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

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| 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 need drugs to treat your illness or condition** More information about prescription drug coverage is available at www.pbdrx.com | Generic drugs / Tier 1 | $5 Copay – Retail<br>$10 Copay – Mail order | Not covered. | Must be filled at a participating pharmacy. |
| | Preferred brand drugs / Tier 2 | $25 Copay – Retail<br>$50 Copay – Mail order | Not covered. | Must be filled at a participating pharmacy. |
| | Non-preferred brand drugs / Tier 3 | $50 Copay – Retail<br>$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 | $50 copayment | Covered as in-network benefit | Copayment waived if admitted |
| | Emergency medical transportation | $25 copayment | Covered as in-network benefit | Must be deemed medically necessary. Wheelchair van transportation is not covered. |
| | Urgent care | In a physician's office:<br>Adult:<br>PCP - $15<br>Specialist - $20<br><br>Child:<br>PCP - $0<br>Specialist -$20<br><br>After Hours Care Center:<br>$35 copayment | 20% coinsurance | Out-of-Area: Members must call the 24-Hour Medical Help Line prior to services being rendered (member pre-certification). |

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

| 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 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 health, behavioral health, or substance abuse services** | Outpatient services | $15 copayment | 20% coinsurance | -None- |
| | 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** | Home health care | $20 copayment | 20% coinsurance | Maximum of 40 visits per plan year. Member |

| 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) | |
| **recovering or have other special health needs** | | | | 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 for each instance. |
| | Hospice services | No charge | 20% coinsurance | 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<br>Bifocal: $70<br>Trifocal: $105<br>Progressive: $135<br>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. | -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 |

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

| 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 5348. 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.

**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.*

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

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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 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** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $65 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$125** |

### 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 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** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $640 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$695** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| 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** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $230 |
| Coinsurance | $7 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$237** |

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