



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: 7/1/2018 – 6/30/2019 | 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: \$1,350 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 <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: \$5,000 Individual/ \$10,000 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 | \$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. |
| | <u>Specialist</u> 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. |
| | <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.

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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 |

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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. |
| 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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|--|---|--|--------------------|--|-----------------------------------|--------------------|---|
| | 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. |

* 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 |
|--|----------------------------------|------------------------|--------------------|-----------------------------|-----------------------------------|-----------------|---|
| | 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 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. 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](#) \$1,350
- [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 |