




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 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 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 ?	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 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.

Important Questions	Answers	Why This Matters:
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
		First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copayment	N/A	N/A	\$20 copayment	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.
	Specialist visit	\$30 copayment	N/A	N/A	\$30 copayment	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

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		First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
							in eligible expenses for each instance.
	Preventive care/screening/immunization	No Charge	No Charge	No Charge	No charge	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. **Routine Physicals are not covered out of network.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: No charge Blood work: No charge	X-Ray: \$20 copayment Blood work: No charge	X-Ray: 20% coinsurance Blood work: 20% coinsurance	X-Ray: \$20 copayment 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 copayment	\$20 copayment	20% coinsurance	\$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.
If you need drugs to treat your illness or condition More information about	Generic drugs	N/A	N/A	N/A	Retail: \$10 copayment Mail order: \$20 copayment	N/A	Must be filled at a participating pharmacy.

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prescription drug coverage is available at www.pbdrx.com	Preferred brand drugs	N/A	N/A	N/A	Retail: \$30 copayment Mail order: \$60 copayment	N/A	Must be filled at a participating pharmacy.
	Non-preferred brand drugs	N/A	N/A	N/A	Retail: \$55 copayment Mail order: \$110 copayment	N/A	Must be filled at a participating pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 copayment	\$125 copayment	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
	Physician/surgeon fees	N/A	N/A	N/A	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	\$125 copayment	\$125 copayment	\$125 copayment	N/A	\$125 copayment	Copayment waived if admitted
	Emergency medical transportation	N/A	N/A	N/A	\$100 copayment	\$100 copayment	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	N/A	N/A	N/A	\$50 copayment	\$50 copayment	--None--
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge*	\$500 copayment*	20% coinsurance*	N/A	20% coinsurance	*If admitted through ER, Covered in Full. Member Precertification may

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

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							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	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	\$20 copayment	\$20 copayment	20% coinsurance	\$20 copayment	20% coinsurance	-None-
	Inpatient services	No charge	\$500 copayment*	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, member liability may apply based on services rendered.
	Childbirth/delivery professional services	N/A	N/A	N/A	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.

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	Childbirth/delivery facility services	No charge	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 copayment	N/A	Erie & Niagara County: 20% coinsurance All other WNY Counties: \$20 copayment	\$20 copayment	20% coinsurance	Limit: No Limit 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 copayment	\$20 copayment	20% coinsurance	\$20 copayment	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	No charge*	\$500 copayment**	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.
	Durable medical equipment	N/A	N/A	N/A	20% coinsurance	50% coinsurance	Member Precertification may be required.
	Hospice services	No charge	No charge	No charge	N/A	20%	Hospice services shall

Common Medical Event	Services You May Need	What You Will Pay					Limitations, Exceptions, & Other Important Information
		First Choice Providers	Specialty Services	Non First Choice Facilities	Par Physician and Ancillary (IHC)	Out-of-Network	
						coinsurance	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
• Weight loss programs	• Hearing aids	• Private-duty nursing
• Cosmetic Surgery	• Long-term care	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic Care	• Infertility treatment	• Bariatric Surgery
• Routine foot care	• Routine eye care (Adult)	

Your Rights to Continue Coverage: 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 on how 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

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



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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

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, kwijjigo 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	\$2,000
■ Specialist [cost sharing]	\$30
■ Hospital (facility) [cost sharing]	\$0
■ Other [cost sharing]	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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$80
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$140

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 [cost sharing]	\$30
■ Hospital (facility) [cost sharing]	\$0
■ Other [cost sharing]	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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$920
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$975

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist [cost sharing]	\$30
■ Hospital (facility) [cost sharing]	\$0
■ Other [cost sharing]	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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$470
Coinsurance	\$7
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$477

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.