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, [insert contact information]. 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 www.[insert].com or call 1-800-[insert] to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network**: $1000 Individual / $2000 Family **Out-of-Network**: $1000 Individual / $2000 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**: $ 4000 Individual / $8000 Family **Out-of-Network**: $4000 Individual / $8000 Family **Pharmacy:** $2500 Individual / $5000 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 and https://providerlocator.firsthealth.com/home/index 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	TRC Primary Care Clinic: Covered in full PCP: $20	40% 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.
	Specialist visit	$20 copayment	40% coinsurance	--None--
	Preventive care/screening/ immunization	No Charge	Not Covered	Certain preventive services are not covered when they are provided out-of-network. You may have to pay for these services. Check to see what your plan will pay for before receiving these services out-of-network. Also, 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% coinsurance Laboratory: $20 copayment	40% coinsurance	Member Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.pbdrx.com/home	Generic drugs	$10 copayment	Not Covered	Administered by PBD 1-888-878-9172
	Preferred brand drugs	$30 copayment	Not Covered	Administered by PBD 1-888-878-9172
	Non-preferred brand drugs	$80 copayment	Not Covered	Administered by PBD 1-888-878-9172
	Specialty drugs	$100 copayment	Not Covered	Administered by PBD 1-888-878-9172
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses

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)	
				up to a maximum of $500 for each instance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--None--
If you need immediate medical attention	Emergency room care	$200 copayment	Covered as in-network benefit	Copayment waived if admitted
	Emergency medical transportation	20% coinsurance	Covered as in-network benefit	Must be deemed medically necessary. Wheelchair van transportation is not covered.
	Urgent care	$50 copayment	40% coinsurance	--None--
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--None--
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copayment	40% coinsurance	--None--
	Inpatient services	20% coinsurance	40% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
If you are pregnant	Office visits	No charge after initial diagnosis	40% 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	20% coinsurance	40% coinsurance	Member Precertification may be required for Home Births.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Member Precertification may be required
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Maximum of **40 visits** per plan year. In-network & out-of-network services combined equal total benefit.
	Rehabilitation services	20% coinsurance	40% coinsurance	Maximum of **20 visits** per plan year (Physical Therapy, Speech Therapy, Occupational Therapy combined).

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)	
				In-network & out-of-network services combined equal total benefit
	Habilitation services	Not covered	Not covered	--None--
	Skilled nursing care	20% coinsurance	40% coinsurance	Maximum of **45 visits** per plan year. In-network & out-of-network services combined equal total benefit.
	Durable medical equipment	50% coinsurance	50% coinsurance	Member Precertification may be required. Failure to obtain precertification could result in up to a 50% reduction of the eligible expenses up to a maximum of $500 for each instance.
	Hospice services	No charge	40% coinsurance	Hospice services shall include supplies & drugs.
If your child needs dental or eye care	Children's eye exam	N/A	N/A	Services covered through VSP 1-800-877-7195
	Children's glasses	N/A	N/A	Services covered through VSP 1-800-877-7195
	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
- Weight Loss programs
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Long Term Care
- Non-Emergency care when traveling outside the US
- Private-duty nursing
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic Care
- Bariatric surgery
- Routine eye care (Adult)
- Infertility Treatment

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the plan at **(716) 631-2661.** 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. Other coverage options may be available to you, too, including buying individual insurance coverage

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

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 contact: Independent Health at 1-800-257-2753.

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, 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.

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	**$1000**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**40%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1000
Copayments	$420
Coinsurance	$1825
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,305**

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

The plan's overall deductible	**$1000**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**40%**

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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1155
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,582**

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

The plan's overall deductible	**$1000**
Specialist *[cost sharing]*	**$20**
Hospital (facility) *[cost sharing]*	**20%**
Other *[cost sharing]*	**40%**

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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$848
Copayments	$60
Coinsurance	$226
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,134**

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