



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, call 1-844-864-4352 or visit us at www.ibxtpa.com. For 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-844-864-4352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	Preferred \$5,500 person / \$5,000 family, Non-Preferred \$5,000 person / \$10,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this 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. Preferred preventive care	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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 ?	For Preferred providers \$6,000 person / \$12,000 family, for Non-Preferred providers \$10,000 person / \$20,000 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 ?	Premiums , balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.	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.ibxtpa.com or call: 1-844-864-4352 for a list of Preferred 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	20% coinsurance	40% coinsurance	Deductible applies. Telemedicine: \$15 copay per consultation (designated vendor only).
	Specialist visit	20% coinsurance	40% coinsurance	Deductible applies.
	Preventive care/screening/immunization	No Charge Deductible waived	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for. Deductible applies to Non-Preferred. Limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some diagnostic services. No charge for lab/x-rays performed as part of ER or hospital care. There is a 20% reduction in benefits if preauthorization is not obtained.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ibxtpa.com	Generic drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	Retail: 30-day supply. Mail order: 90-day supply. Prior authorization is required for certain medications. If you receive a brand medication when there is a generic alternative, you will pay the difference in the cost of the medication in addition to the applicable brand cost-share .
	Preferred brand drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	
	Non-preferred drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	Prior authorization is required for certain medications. Specialty drugs will be paid at the formulary level, copays will vary. If you receive a brand medication when there is a generic alternative, you will pay the difference in the cost of the medication in addition to the applicable brand cost-share .
	Specialty drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Deductible applies.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Habilitation services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	---None---
	Children's glasses	Not Covered	Not Covered	---None---
	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 | • Hearing Aids | • Routine eye care (Adult) |
| • Cosmetic surgery | • Infertility Treatment | • Weight loss programs |
| • Dental care (Adult) | • Long Term Care | |

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

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|---------------------|--|---------------------|
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com) | • Routine foot care |
| • Chiropractic care | • Private-duty nursing | |

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: U.S. Department of Labor, 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 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: 1-844-864-4352 or www.ibxtpa.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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?

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 1-844-864-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-864-4352.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-844-864-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-844-864-4352.

—————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	\$5,500
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ 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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,500
Copayments	\$0
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$5,500
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ 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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,400
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$5,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,500
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*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:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,800

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