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 **$1,000** person / **$2,000** 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 and services that require a copay. There is no Preferred deductible.	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	$25 copay per visit Deductible waived	30% coinsurance	Telemedicine: $15 copay per consultation (designated vendor only).
	Specialist visit	$50 copay per visit Deductible waived	30% coinsurance	---None---
	Preventive care/screening/ immunization	No Charge	30% 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)	$25 copay per visit Deductible waived	30% coinsurance	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)	$25 copay per scan Deductible waived	30% 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: $10 copay per fill	Retail and Mail Order: $10 copay per fill	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. If you are taking a maintenance medication, you will be allowed to fill it two times at a retail pharmacy, and additional refills will only be covered when filled though the mail order service.
	Preferred brand drugs	$35 copay per fill retail $50 copay per fill mail order	$35 copay per fill retail $50 copay per fill mail order	
	Non-preferred drugs	$65 copay per fill retail $100 copay per fill mail order	$65 copay per fill retail $100 copay per fill mail order	
	Specialty drugs	$65 copay per fill retail $100 copay per fill mail order	$65 copay per fill retail $100 copay per fill mail order	Prior authorization is required for certain medications. Specialty drugs will be paid at the formulary level, copays will vary.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	100% coinsurance	30% 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	No Charge	30% coinsurance	

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 need immediate medical attention	Emergency room care	$500 copay per visit	$500 copay per visit	Non-emergency Non-Preferred: $100 copay then 30% coinsurance. Copay is waived if admitted.
	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	$50 copay per visit Deductible waived	$50 copay per visit Deductible waived	Non-emergency Non-Preferred is $50 copay then 30% coinsurance. Copay is waived if admitted.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coinsurance for 5-day max.	30% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Physician/surgeon fees	No Charge	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit Deductible waived	30% coinsurance	---None---
	Inpatient services	100% coinsurance for 5-day max	30% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
If you are pregnant	Office visits	$50 copay per visit Deductible waived	30% coinsurance	Copay may apply to the first prenatal visit appointment.
	Childbirth/delivery professional services	No Charge	30% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Childbirth/delivery facility services	100% coinsurance for 5-day max	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	$50 copay per visit Deductible waived	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained.
	Rehabilitation services	$50 copay per visit Deductible waived	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
	Habilitation services	$50 copay per visit Deductible waived	30% coinsurance	Deductible applies. Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
	Skilled nursing care	$50 copay per day Deductible waived	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained.
	Durable medical equipment	$50 copay per item Deductible waived	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained.

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)	
	Hospice services	No Charge	30% coinsurance	Deductible applies. Preauthorization is required for some outpatient surgeries. 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
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine eye care (Adult)
- Weight loss programs

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

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

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? **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 1-844-864-4352.
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, kwiijigo 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	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other no cost sharing	$0

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	$1,000
Copayments	$400
Coinsurance	$4,600
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	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other no cost sharing	$0

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	$1,000
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	$1,000
Specialist copayment	$50
Hospital (facility) coinsurance	100%
Other no cost sharing	$0

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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