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.ibx.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 **$500** person / **$1,000** family, Non-Preferred **$3,500** person / **$7,000** 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.	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.ibx.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	$30 copay per visit	40% coinsurance	---None---
	Specialist visit	$40 copay per visit	40% coinsurance	---None---
	Preventive care/screening/ immunization	No Charge	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Precertification may be required for some services. There is a 25% reduction in benefits if precertification is not obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$5 copay per fill (retail) $10 copay per fill (mail order)	Not Covered	Medical deductible does not apply to prescription drug costs. Covers up to a 30-day supply at retail and a 31-90-day supply at mail order.
	Preferred brand drugs	20% coinsurance (retail and mail order)	Not Covered	
	Non-preferred drugs	20% coinsurance (retail and mail order)	Not Covered	
	Specialty drugs	20% coinsurance (retail and mail order)	Not Covered	--None--
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---None---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	---None---
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance after Preferred deductible	Non-emergency is covered at 20% coinsurance, after deductible, for both Preferred and Non-Preferred.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Must be medically necessary.
	Urgent care	20% coinsurance	40% coinsurance	---None---

If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	20% coinsurance	40% 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 mental health, behavioral health, or substance abuse services	Outpatient services	$40 copay per visit	40% coinsurance	---None---
	Inpatient services	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
If you are pregnant	Office visits	$30 copay per visit	40% coinsurance	Copay for first prenatal visit only.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limitations may apply.
	Rehabilitation services	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limitations may apply.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limited to 120 days per year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limitations may apply.
	Hospice services	20% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limitations may apply.
If your child needs dental or eye care	Children's eye exam	$40 copay per visit	Not Covered	One visit per year, no hardware. This benefit applies to all enrolled members.
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long Term Care
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (if medically necessary)
- Chiropractic care (30 visits per calendar year)
- Infertility Treatment (10% coinsurance after deductible, up to $10,00 lifetime maximum.)
- Most coverage provided outside the U.S.
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)
- Private-duty nursing
- 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: 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.ibx.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, 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	$500
Specialist copayment	$40
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$40
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,500**

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

The plan's overall deductible	$500
Specialist copayment	$40
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$3,100
The total Joe would pay is	**$4,100**

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

The plan's overall deductible	$500
Specialist copayment	$40
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-864-4352 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغ ميسّرة ومناسبة. يُرجى الاتصال على الرقم 1-844-864-4352 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃ◌ আকষণ : যিদ আপিন বাংলাভাষী হন, তাহেল আপনার জন্য িবনামূেল্য ভাষা সহায়তা পিরেষবা উপল◌ অ্যাে িসবল ফরম্যাটে তথ্য ◌দান করার জন্য উপযু◌ সহায়ক উপকরণ ও পিরেষবা িবনামূেল্য উপল◌ 1-844-864-4352 (TTY: 711) ন েের কল ক◌ন বা আপনার ◌দানকারীর সে◌ েযাগােযাগ ক◌ন।

普通话: 注意：如果您说普通话，我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务，确保以无障碍格式传递信息。请致电 1-844-864-4352（TTY：711）或咨询服务提供者。

فارسی: توجه: اگر به فارسی صحبت می‌کنید، خدمات رایگان زبان در دسترس شما است. کمک‌ها و خدمات جانبی مناسب برای ارائه اطلاعات در قالبهای قابل دسترس نیز به صورت رایگان موجود است. با شماره 1-844-864-4352 (TTY:711) تماس بگیرید یا با ارائه‌کننده‌تان صحبت کنید.

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-864-4352 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib ki disponib tou gratis. Rele nan 1-844-864-4352 (TTY: 711) oswa pale ak founisè w la.

ુજરાતી: ધ્યાન આપો: જો તમે ુજરાતી બોલો છો, તો તમાર◌ માટ◌ મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. ુલભ સ્વરૂપમાં મા◌હતી ૂર◌પાડવા માટ◌યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-844-864-4352 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતાનો સંપકર્ કરો.

Lus Hmoob: TSEEM CEEB: Yog hais tias koj hais Lus Hmoob, yuav muaj kev pab txhais lus dawb rau koj. Tsis tas li ntawd, kuj tseem muaj cov kev pab thiab cov kev pab cuam tsim nyog los muab cov ntaub ntawv hauv cov qauv siv tau yam tsis tau them nyiaj. Hu rau 1-844-864-4352 (TTY: 711) los sis tham nrog koj tus kws muab kev pab cuam.

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-844-864-4352 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-844-864-4352 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

ကညီကျိ ဟ်သူဉ်ဟ်သးတက့ာ်- နမ့ာ်စံးကတိၤ [ကညီကိျာ်]နှဉ်, တာ်မၤစၢၤဘဉ်ဃးဒီး ကိျာ်တာ်ကတိၤ အတာ်မၤလၢ ဘူးလဲကလိနှဉ် နဒိးနှ်အီၤသ့လီၤ. ပီးလီမၤစၢၤ ပှၤက့ာ်ဂီၤတဆူဉ်တကျၢၤတဖဉ်ဒီး တာ်တိစၢမၤစၢၤအတာ်မၤတဖဉ်လၢအ◌ကၢးအဘဉ် လၢကဟ့ဉ်တာ်ဂ့ာ်တာ်ကိျၤနှဉ် တာ်ဒိးနှ်အီၤသ့လၢ ကှာ်ဂီၤလၢတာ်ဒိးနှ်အီၤညီ လၢအဘူးအလဲကလိစ့ာ်ကီးနှဉ်လီၤ. ကိး 1-844-864-4352 (TTY:711) မ့တမ့ာ် ကတိၤတာ်ဒီး နပှၤဟ့ဉ်မၤစၢၤတာ်တက့ာ်.

한국어를: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-844-864-4352 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yáníłti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjį' bee adahodooníłí diné bich'į' anídahazt'i'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'i'go hadadilyaaígííałdó' t'áá jiik'eh hǫlǫ́. Kohjį' 1-844-864-4352 (TTY: 711) hodíilnih doodago níka'análawo'í bich'į' hanidziih.

Anishinaabemoyan: WAABANDAN O'OW: Giishpin Anishinaabemoyan, gidaa-wiidookaagoo wenipazh ji-nisidotaagoziyan giishpin nandawendaman. Anooj gegoon dash gidaa-wiidookaagoo ji-nisidawendaagoziyan wenipazh gaye. Aabajitoon o'ow asigibii'igan 1-844-864-4352 (TTY:711) gemaa dash

gaganoozh mino-ayaawin waadookaaged.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-844-864-4352 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-844-864-4352 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-844-864-4352 (TTY: 711) или обратитесь к своему провайдеру.

Soomali: FIIRO GAAR AH: Haddii aad ku hadashid Soomaali, adeegyada caawinta luuqada ayaa laguu heli karaa. Caawinada maqalka ku haboon iyo adeegyo lagu bixinayo warbixinta qaababka lagu heli karo ayaa sidoo kale lagu heli karaa si bilaash ah. Ka soo wac 1-844-864-4352 (TTY:711) ama la hadal bixiyahaaga.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-844-864-4352 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-844-864-4352 (TTY:711) o makipag-usap sa iyong provider.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-844-864-4352 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Discrimination Is Against the Law

Independence Administrators complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence Administrators does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact our Civil Rights Coordinator.

If you believe that Independence Administrators has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: our Civil Rights Coordinator, in person or by mail:

ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA, 19103, by phone: 1-844-864-4352 (TTY: 711), by fax: 215-761-0920, or by email: **IACivilRightsCoordinator@ibxtpa.com**.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington,
D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**. This notice is available at**:** **www.ibxtpa.com**.