



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 \$250 person / \$500 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. Preferred preventive care and services that require a copay .	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 \$5,000 person / \$10,000 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 copay per visit	40% coinsurance	---None---
	Specialist visit	\$30 copay per visit	40% coinsurance	---None---
	Preventive care/screening/immunization	No Charge Deductible waived	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)	10% coinsurance	40% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	10% 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 (retail prescription); 31–90-day supply (mail order prescription); \$500 fertility drug lifetime max.
	Preferred brand drugs	20% coinsurance retail 20% coinsurance mail order	Not Covered	
	Non-preferred drugs	20% coinsurance retail 20% coinsurance mail order	Not Covered	
	Specialty drugs	20% coinsurance retail 20% coinsurance mail order	Not Covered	---None---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	---None---
	Physician/surgeon fees	10% coinsurance	40% coinsurance	---None---
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance after Preferred deductible	Non-emergency is covered at 10% coinsurance , after deductible , for both Preferred and Non-Preferred.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Must be medically necessary .
	Urgent care	10% coinsurance	40% coinsurance	---None---

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)	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 copay per visit	40% coinsurance	---None---
	Inpatient services	10% 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	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
If you need help recovering or have other special health needs	Home health care	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Rehabilitation services	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained.
	Habilitation services	10% coinsurance	40% coinsurance	
	Skilled nursing care	10% 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	10% coinsurance	40% coinsurance	Precertification is required. There is a 25% reduction in benefits if precertification is not obtained. Limitations may apply.
	Hospice services	10% 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	\$30 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 | • Hearing Aids | • Routine foot care |
| • Dental care (Adult) | • Long Term 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 | • Infertility Treatment (10% coinsurance after deductible , up to \$10,00 lifetime maximum.) | • Private-duty nursing |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com) | • Routine eye care (Adult) |
| • Chiropractic care (30 visits per calendar year) | | |

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](#).

Nondiscrimination Notice and Notice of Availability of Auxiliary Aids and Services

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 differently because of race, color, national origin, age, disability, or sex.

Independence Administrators:

- Provides free aids and services to people with disabilities to communicate effectively with us and written information in other formats, such as large print
- Provides free language services to people whose primary language is not English and information written in other languages

If you need these 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.

There are four ways to file a grievance directly with Independence Administrators:

- by mail: Independence Administrators,
ATTN: Civil Rights Coordinator, 1900 Market Street, Philadelphia, PA 19103;
- by phone: 844-864-4352 (TTY 711);
- by fax: 215-761-0920; or
- by email: IACivilRightsCoordinator@ibxtpa.com.

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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Services:

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-864-4352 (TTY: 711).

Spanish: ATENCIÓN: Si usted habla inglés, tiene a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-844-864-4352(TTY: 711).

Chinese: 请注意：如果您说[中文]，则可以免费使用语言协助服务。请致电 1-844-864-4352 (TTY: 711)。

Hmong: LUS CEEB TOOM: Yog tias koj hais LUS HMOOB, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj. Hu rau tus xov tooj 1-844-864-4352 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói [người việt nam], bạn sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi 1-844-864-4352(TTY: 711).

Somali: FIIRO GAAR AH: Haddii aad ku hadashid luuqada Soomaaliga, adeegyada caawinta luuqada, oo bilaash ah, ayaa lagu helayaa. Soo wac 1-844-864-4352 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги переводчика. Позвоните 1-844-864-4352 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، تم توفير خدمات المساعدة اللغوية مجاناً، اتصل بالرقم ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١).

French : ATTENTION : Si vous parlez le français, des services d'assistance linguistique gratuits, vous sont proposés. Appelez le 1-844-864-4352 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Sprachassistent zur Verfügung. Rufen Sie unter der Nummer 1-844-864-4352 (TTY: 711) an.

Amharic: ትኩረት: [አማርኛ] የሚናገሩ ከሆነ ከክፍያ ገንዘብ የቋንቋ አገልግሎት በገጽ ያገኛሉ። 1-844-864-4352(TTY: 711) ላይ ይደሉ።

Korean: 주의: [한국어]를 사용하는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-844-864-4352로 전화해주십시오. (TTY: 711).

Lao: ສົ່ງຄວາມສະຫງວນ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ໄດ້ຂອບຄ່າ. ໂທ 1-844-864-4352 (TTY: 711).

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, libre na available sa iyo ang mga serbisyo sa tulong sa wika. Tumawag sa 1-844-864-4352 (TTY: 711).

Navajo: Áhéhéé': T'áá a'nííł nígíí bizaad yádaaltł'í nisin, yá'át'éehá ánída'át nisin, ákót'éego bee hółǫ́, bizaad yádaaltł'í nisin dah nishłí, yaałtsoh da t'ááji'ígíí ashkíí. 1-844-864-4352 t'áá baa yáshtí'. (TTY: 711).

Khmer: ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានប្រសិទ្ធភាពក្នុងការស្វែងរកសេវាជំនួយភាសាដោយឥតគិតថ្លៃឡើយ។ ហៅទូរសព្ទទៅលេខ 1-844-864-4352(TTY: 711)។

Italian: ATTENZIONE: Per coloro che parlano italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamare al numero 1-844-864-4352 (TTY: 711).

Guajarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-864-4352 (TTY: 711) પર કોલ કરો.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Zadzwoń pod numer 1-844-864-4352 (telefon tekstowy: 711).

Creole: ATANSYON: Si ou pale kreyòl, sèvis asistans lang yo gratis, e yo disponib pou ou. Rele nan 1-844-864-4352 (TTY: 711).

Portuguese: ATENÇÃO: Se você fala português, os serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue 1-844-864-4352 (TTY: 711).

Japanese: 注記：[日本語] 話者向けの無料の言語支援サービスを利用できます。電話 1-844-864-4352 (TTY: 711)。

Farsi: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی، به صورت رایگان در دسترس شما است. با شماره ١٧٠٦-٣٥٢-٨٤٤ تماس بگیرید (TTY: ٧١١).

Urdu: متوجہ ہوں: اگر آپ اردو بولتے ہیں، تو زبان کی معاونت کی خدمات، آپ کے لیے مفت دستیاب ہیں۔ ١٧٠٦-٣٥٢-٨٤٤-١ (TTY: ٧١١) پر کل کریں۔

Hindi: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-864-4352(TY: 711) पर कॉल करें।

Telugu: ధ్యాన పెట్టండి: మీరు తెలుగు మాట్లాడగలిగితే, భాషా సహాయక సేవలు మీకు ఉచితంగా లభిస్తాయి. 1-844-864-4352 (TTY: 711)కు కాల్ చేయండి.

Swahili: KUMBUKA: Iwapo unazungumza Kiswahili, utapata huduma za usaidizi wa lugha bila malipo. Piga simu kwa 1-844-864-4352 (TTY: 711).

Ojibwe: AMBE: Giishipin wii'wiidookaagooyan ii-noondam Ojibwemowin. ganoozhishinaam 1-844-864-4352 (TTY: 711) Gawain gidaw-diba'anziin.

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	\$250
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$250
Copayments	\$40
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,350

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$250
Copayments	\$300
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,270

Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$30
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

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	\$250
Copayments	\$100
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$550

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