

⚠ 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 <u>deductible</u> ?	Preferred \$2,000 person / \$4,000 family, Non-Preferred \$5,000 person / \$10,000 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For Preferred <u>providers</u> \$3,000 person / \$6,000 family, for <u>Non-Preferred providers</u> \$10,000 person / \$20,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, health care this <u>plan</u> doesn't cover, and <u>preauthorization</u> penalties.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.ibxtpa.com or call: 1-844-864-4352 for a list of Preferred providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	No Charge after deductible	50% coinsurance	---None---
	Specialist visit	No Charge after deductible	50% coinsurance	---None---
	Preventive care/screening/immunization	No Charge Deductible waived	50% coinsurance Deductible waived	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)	No Charge after deductible	50% coinsurance	---None---
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	50% coinsurance	Precertification required for certain services. There may be a 20% 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.ibxtpa.com	Generic drugs	\$15 copay per fill retail \$30 copay per fill mail order	50% coinsurance retail Mail Order Not Covered	Prior authorization required on some drugs; age and quantity limits may apply; 30-day supply limit on retail and 90-day supply on mail order for maintenance drugs.
	Preferred brand drugs	\$35 copay per fill retail \$70 copay per fill mail order	50% coinsurance retail Mail Order Not Covered	
	Non-preferred drugs	\$50 copay per fill retail \$100 copay per fill mail order	50% coinsurance retail Mail Order Not Covered	
	Specialty drugs	No Charge	50% coinsurance	The cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self-administered specialty drugs follow the applicable retail prescription cost-share under the Optum Specialty Pharmacy Program. Prior authorization required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	50% coinsurance	Precertification is required for some outpatient surgeries. There may be a 20% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	No Charge after deductible	50% 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	No Charge after deductible	15% coinsurance	Preferred deductible applies.
	Emergency medical transportation	No Charge after deductible	15% coinsurance	Preferred deductible applies.
	Urgent care	No Charge after deductible	50% coinsurance	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	50% coinsurance	Precertification is required. There may be a 20% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	No Charge after deductible	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	50% coinsurance	Precertification may be required. There may be a 20% reduction in benefits if precertification is not obtained.
	Inpatient services	No Charge after deductible	50% coinsurance	Precertification is required. There may be a 20% reduction in benefits if precertification is not obtained.
If you are pregnant	Office visits	No Charge after deductible	50% coinsurance	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copay , or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Precertification is required for maternity care. There may be a 20% reduction in benefits if precertification is not obtained.
	Childbirth/delivery professional services	No Charge after deductible	50% coinsurance	
	Childbirth/delivery facility services	No Charge after deductible	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge after deductible	50% coinsurance	Precertification may be required. There may be a 20% reduction in benefits if precertification is not obtained.
	Rehabilitation services	No Charge after deductible	50% coinsurance	Physical/Occupational Therapies have limit of 30 visits combined per benefit period. Speech Therapy has limit of 20 visits per benefit period. All visit limits combined in and out-of- network .
	Habilitation services	No Charge after deductible	50% 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)	
	Skilled nursing care	No Charge after deductible	50% coinsurance	Precertification may be required. There may be a 20% reduction in benefits if precertification is not obtained.
	Durable medical equipment	No Charge after deductible	50% coinsurance	Precertification may be required. There may be a 20% reduction in benefits if precertification is not obtained.
	Hospice services	No Charge after deductible	50% coinsurance	Precertification may be required. There may be a 20% reduction in benefits if precertification is not obtained.
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 | • 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.)

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

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:

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

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-864-4352 (TTY: 711).

注意：如果您使用简体中文，您可以免费获得语言协助服务。请致电1-844-864-4352。

LƯU Ý: Nếu quý vị nói tiếng Việt, có dịch vụ trợ giúp ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-844-864-4352.

ВНИМАНИЕ: Если вы говорите по-русски, вам предлагаются бесплатные услуги переводчика. Позвоните по телефону 1-844-864-4352.

Wann du [Deutsch (Pennsylvania German / Dutch)] schwetzscht, kannst du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-864-4352.

알림: 한국어 통역서비스가 필요한 분은 1-844-864-4352로 전화하십시오.

통역서비스를 무료로 받으실 수 있습니다.

ATTENZIONE: se parla italiano, sono disponibili per lei servizi di assistenza linguistica gratuiti. Contatti il numero 1-844-864-4352.

انتباه: إذا كنت تتحدث العربية فإن خدمات المساعدة اللغوية متوفرة لك مجاناً. اتصل على الرقم: 1-844-864-4352.

ATTENTION: Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Appelez le 1-844-864-4352.

HINWEIS: Wenn Sie Deutsch sprechen, steht Ihnen über Language Assistance Services ein Dolmetscher kostenlos zur Verfügung. Wählen Sie 1-844-864-4352.

ધ્યાન આપો : જો તમે ગુજરાતી બોલી શકતા હો, તો તમારા માટે ભાષા સહાય સેવાઓ, વિના મૂલ્યે, ઉપલબ્ધ છે. 1-844-864-4352 પર કોલ કરો.

UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-864-4352.

ATANSYON: Si ou pale kreyòl ayisyen, gen asistans ak lang disponib pou ou gratis. Rele 1-844-864-4352.

ចំណាំ: ប្រសិនបើអ្នកនិយាយភាសា មន-ខ្មែរ ឬទេសខ្មែរ សេវាជំនួយភាសាដែលឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ 1-844-864-4352។

ATENÇÃO: se você fala português, serviços de assistência a idioma estão disponíveis gratuitamente para você. Ligue para 1-844-864-4352.

BAA !KON&N&ZIN: Din4 bizaad bee yln7[ti'go, ata' hane' bee lk1 i'iilyeed t'l1 j77k'e bee n1 ah00t'i'. Koj8' hod77lnih 1-844-864-4352.

PAUNAWA: Kung nagsasalita ka ng Tagalog, makakakuha ka ng mga serbisyo ng tulong para sa wika nang walang bayad. Tumawag sa 1-844-864-4352.

注意：日本語をお話しになる場合は、言語支援サービスを無料でご利用いただけます。1-844-864-4352にお電話ください。

توجه: اگر به زبان فارسی صحبت می کنید، خدمات کمک در زمینه زبان، به رایگان در اختیار شما می باشد. با شماره 1-844-864-4352 تماس بگیرید.

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	\$2,000
■ Specialist no cost sharing	\$0
■ Hospital (facility) no cost sharing	\$0
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,070

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist no cost sharing	\$0
■ Hospital (facility) no cost sharing	\$0
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist no cost sharing	\$0
■ Hospital (facility) no cost sharing	\$0
■ Other no cost sharing	\$0

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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