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 **$0** person / **$0** family, Non-Preferred **$500** person / **$1,500** 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. 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 **$6,600** person / **$13,200** family, for Non-Preferred providers **$6,600** person / **$13,200** family. Includes deductible and coinsurance.	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	30% coinsurance	---None---
	Specialist visit	$45 copay per visit	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. Limitations may apply. Copay may be applied if the office visit is billed separately.
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay per visit	30% coinsurance	Preauthorization is required for some diagnostic services. Copay not applicable when service performed in ER or office setting. There is a 20% penalty if preauthorization is not obtained.
	Imaging (CT/PET scans, MRIs)	$60 copay per scan	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	$5 copay per fill retail $10 copay per fill mail order	$5 copay per fill retail $10 copay per fill mail order	Retail: 30-day supply. Mail order: 90-day supply. Copay is 2 times retail copay.
	Preferred brand drugs	$30 copay per fill retail $60 copay per fill mail order	$30 copay per fill retail $60 copay per fill mail order	
	Non-preferred drugs	$50 copay per fill retail $100 copay per fill mail order	$50 copay per fill retail $100 copay per fill mail order	
	Specialty drugs	$50 copay per fill retail $100 copay per fill mail order	$50 copay per fill retail $100 copay per fill mail order	Specialty drugs will be paid at the formulary level. Copays will vary.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay per visit	30% coinsurance	Preauthorization is required for some outpatient surgeries. Copay not waived if admitted. There is a 20% penalty if preauthorization is not obtained.
	Physician/surgeon fees	No Charge	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% penalty if preauthorization is not obtained.
If you need	Emergency room care	$150 copay per visit	$150 copay per visit	---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)	
immediate medical attention	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	$45 copay per visit	30% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	$300 copay per day up to 5 copays per admission	30% coinsurance	Preauthorization is required. There is a 20% penalty 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	$45 copay per visit	30% coinsurance	---None---
	Inpatient services	$300 copay per day up to 5 copays per admission	30% coinsurance	Preauthorization is required. There is a 20% penalty if preauthorization is not obtained.
If you are pregnant	Office visits	$25 copay per visit	30% coinsurance	Preauthorization is required. Copay may apply to the first OB appointment. There is a 20% penalty if preauthorization is not obtained.
	Childbirth/delivery professional services	No Charge	30% coinsurance	Preauthorization is required. There is a 20% penalty if preauthorization is not obtained.
	Childbirth/delivery facility services	$300 copay per day up to 5 copays per admission	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Preauthorization is required. There is a 20% penalty if preauthorization is not obtained.
	Rehabilitation services	$45 copay per visit	30% coinsurance	Preauthorization is required. Limitations may apply. There is a 20% penalty if preauthorization is not obtained.
	Habilitation services	$45 copay per visit	30% coinsurance	
	Skilled nursing care	$300 copay per day up to 5 copays per admission	30% coinsurance	Preauthorization is required. Limited to 120 days per plan year. There is a 20% penalty if preauthorization is not obtained.
	Durable medical equipment	50% coinsurance	70% coinsurance	Preauthorization is required. There is a 20% penalty if preauthorization is not obtained.
	Hospice services	No Charge	30% coinsurance	Preauthorization is required. There is a 20% penalty 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)	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	Limited to one visit every two years. See Davis Vision benefit schedule for additional details.
	Children's glasses	No Charge	Not Covered	Limited to once every two years. See Davis Vision benefit schedule for additional details.
	Children's dental check-up	No Charge	See Benefit Schedule for limitations.	See United Concordia Dental benefit schedule.

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
- Hearing Aids
- Infertility Treatment
- 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.)

- Bariatric surgery
- Chiropractic care (20 visits per calendar year)
- Dental care (Adult)
- 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.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 [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht 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 કૉલ 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 ប្រទេសខ្មែរ 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 y1n7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 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 1-844-864-4352تماس 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	$0
Specialist copayment	$45
Hospital (facility) copayment	$300
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	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$960**

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

The plan's overall deductible	$0
Specialist copayment	$45
Hospital (facility) copayment	$300
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	$0
Copayments	$900
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	$0
Specialist copayment	$45
Hospital (facility) copayment	$300
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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