




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 \$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?	Yes. \$100 individual / \$250 family prescription drug deductible . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan ?	For Preferred providers \$5,000 person / \$10,000 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.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	\$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.ibx.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	\$100 individual / \$250 family prescription deductible applies. Retail: 30- to 90-day supply, 1 copay applies for each 30-day supply. Mail order: 90-day supply. Copay is 2 times retail copay . Specialty drugs will be paid at the formulary level. Copays will vary.
	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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Preauthorization is required for some outpatient surgeries. There is a 20% penalty if preauthorization is not obtained.
	Physician/surgeon fees	No Charge	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$150 copay per visit	\$150 copay per visit	---None---
	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	\$100 copay per visit	30% coinsurance	---None---
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Preauthorization is required. There is a 20% penalty 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$45 copay per visit	30% coinsurance	---None---
	Inpatient services	10% coinsurance	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	Copay may apply to the first OB appointment. Preauthorization is required. There is a 20% penalty if preauthorization is not obtained.
	Childbirth/delivery professional services	No Charge	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	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	Preauthorization is required. Limitations may apply. There is a 20% penalty if preauthorization is not obtained.
	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.
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	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 | • Infertility Treatment | • Weight loss programs |
| • Cosmetic surgery | • Long Term Care | |
| • Hearing Aids | • Routine foot care | |

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

- | | | |
|---|--|----------------------------|
| • Bariatric surgery | • Dental care (Adult) | • Private-duty nursing |
| • Chiropractic care (20 visits per calendar year) | • Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com) | • 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, kwijigo 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	\$0
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	10%
■ 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	\$10
Copayments	\$600
Coinsurance	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,370

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) coinsurance	10%
■ 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	\$100
Copayments	\$900
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,420

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$45
■ Hospital (facility) coinsurance	10%
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$10
Copayments	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$710

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 مجاناً لضمان وصول المعلومات إليك بصيغ ميسرة ومناسبة. يُرجى الاتصال على الرقم 1-844-864-4352 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-844-864-4352 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

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 ed 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.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-844-864-4352 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક 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。

ကညီကျိာ် ဟ်သ့ဟ်သးတက့ၢ်- နမ့ၢ်စးကတိၤ [ကညီကျိာ်]န့ၣ်, တၢ်မၤစၢၤဘၣ်ဃးဒီး ကျိာ်တၢ်ကတိၤ အတၢ်မၤလၢ ဘူးလဲကလိန့ၣ် ဒီးန့ၣ်အိၤသ့လီၤ. ပီးလီၤမၤစၢၤ ပုၤက့ၢ်ဂီၤတဆူၣ်တကျါတဖၣ်ဒီး တၢ်တိၤမၤစၢၤအတၢ်မၤတဖၣ်လၢအကြးအဘၣ် လၢကဟ့ၣ်တၢ်ဂ့ၢ်တၢ်ကျိၤန့ၣ် တၢ်ဒီးန့ၣ်အိၤသ့လၢ က့ၢ်ဂီၤလၢတၢ်ဒီးန့ၣ်အိၤညီ လၢအဘူးအလဲကလိစ့ၢ်ကိးန့ၣ်လီၤ. ကိး 1-844-864-4352 (TTY: 711) မ့တမ့ၢ် ကတိၤတၢ်ဒီး နပုၤဟ့ၣ်မၤစၢၤတၢ်တက့ၢ်.

한국어: 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 binahjì' bee adahodooníłí diné bich'í' anídahazt'í'í bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaígíí ałdó' t'áá jiik'eh hóló. Kohjì' 1-844-864-4352 (TTY: 711) hodíłłnih doodago níka'análawo'í bich'í' hanidzihi.

Anishinaabemoyan: WAABANDAN O'OW: Giishpin Anishinaabemoyan, gidaa-wiidoookaagoo wenipazh ji-nisidotaagoziyan giishpin nandawendaman. Anooj gegoon dash gidaa-wiidoookaagoo 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 lagu 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**.