



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](http://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:
<b>What is the overall <a href="#">deductible</a>?</b>	Preferred <b>\$1,000</b> person / <b>\$2,000</b> family, Non-Preferred <b>\$1,500</b> person / <b>\$3,000</b> family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> and services that require a <a href="#">copay</a> . There is no Preferred <a href="#">deductible</a> under this <a href="#">plan</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For Preferred <a href="#">providers</a> <b>\$3,000</b> person / <b>\$6,000</b> family, for <a href="#">Non-Preferred providers</a> <b>\$4,000</b> person / <b>\$12,000</b> family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , Non-Preferred <a href="#">deductibles</a> , <a href="#">balance-billed</a> charges, health care this <a href="#">plan</a> doesn't cover, and <a href="#">preauthorization</a> penalties.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="http://www.ibx.com">www.ibx.com</a> or call: <b>1-844-864-4352</b> for a list of Preferred <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	—None—
	<a href="#">Specialist</a> visit	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	—None—
	<a href="#">Preventive care/screening/immunization</a>	No Charge	30% <a href="#">coinsurance</a> <a href="#">Deductible</a> waived	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for. Frequency schedules may apply.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	30% <a href="#">coinsurance</a>	—None—
	Imaging (CT/PET scans, MRIs)	\$50 <a href="#">copay</a> per scan	30% <a href="#">coinsurance</a>	Precertification is required for some imaging services. There is a 20% reduction in benefits if precertification is not obtained.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ibx.com">www.ibx.com</a>	Generic drugs	\$20 <a href="#">copay</a> per fill retail \$40 <a href="#">copay</a> per fill mail order	30% <a href="#">coinsurance</a> retail 30% <a href="#">coinsurance</a> mail order	Retail: 30-day supply. Mail order: 90-day supply. Prior authorization required on some drugs; age, gender and quantity limits for some drugs.
	Preferred brand drugs	\$40 <a href="#">copay</a> per fill retail \$80 <a href="#">copay</a> per fill mail order	30% <a href="#">coinsurance</a> retail 30% <a href="#">coinsurance</a> mail order	
	Non-preferred drugs	\$70 <a href="#">copay</a> per fill retail \$140 <a href="#">copay</a> per fill mail order	30% <a href="#">coinsurance</a> retail 30% <a href="#">coinsurance</a> mail order	
	<a href="#">Specialty drugs</a>	No Charge retail	30% <a href="#">coinsurance</a> retail	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	Precertification is required for some outpatient surgeries. There is a 20% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a>	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> per visit	\$100 <a href="#">copay</a> per visit	Your costs for emergency room services are not waived if you are admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	No Charge	No Charge	—None—
	<a href="#">Urgent care</a>	\$70 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	Your costs for <a href="#">urgent care</a> are based on care received at a designated <a href="#">urgent care</a> center or facility, not your physician's office. Costs may vary depending on where you receive care.

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)	\$500 <a href="#">copay</a> per day per admission	30% <a href="#">coinsurance</a>	Precertification is required. There is a 20% reduction in benefits if precertification is not obtained.
	Physician/surgeon fees	No Charge	30% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	—None—
	Inpatient services	\$500 <a href="#">copay</a> per day per admission	30% <a href="#">coinsurance</a>	Precertification is required. There is a 20% reduction in benefits if precertification is not obtained.
If you are pregnant	Office visits	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	Your cost is for the first prenatal visit only.
	Childbirth/delivery professional services	No Charge	30% <a href="#">coinsurance</a>	Precertification is required. There is a 20% reduction in benefits if precertification is not obtained.
	Childbirth/delivery facility services	\$500 <a href="#">copay</a> per day per admission	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	—None—
	<a href="#">Rehabilitation services</a>	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	The following limits are per benefit period: Physical & Occupational Therapies combined - 30 visits; Speech Therapy - 20 visits.
	<a href="#">Habilitation services</a>	\$50 <a href="#">copay</a> per visit	30% <a href="#">coinsurance</a>	Limit of 120 days per benefit period. Precertification is required. There is a 20% reduction in benefits if precertification is not obtained.
	<a href="#">Skilled nursing care</a>	\$500 <a href="#">copay</a> per day per admission	30% <a href="#">coinsurance</a>	
	<a href="#">Durable medical equipment</a>	No Charge	50% <a href="#">coinsurance</a>	Precertification is required on purchases over \$500 (including repairs and replacements) and on all rentals. There is a 20% reduction in benefits if precertification is not obtained.
	<a href="#">Hospice services</a>	No Charge	30% <a href="#">coinsurance</a>	—None—
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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Long Term Care</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Infertility Treatment (limited to artificial insemination)</li></ul>	<ul style="list-style-type: none"><li>• Most coverage provided outside the U.S.</li><li>• Non-emergency care when traveling outside the U.S. (See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a>)</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul>

**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](http://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](http://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](http://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](http://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](#).

### 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](#) \$1000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$500
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1000
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,760</b>

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

- The [plan's](#) overall [deductible](#) \$1000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$500
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1000
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,020</b>

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

- The [plan's](#) overall [deductible](#) \$1000
- [Specialist copayment](#) \$50
- Hospital (facility) [copayment](#) \$500
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$1000
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,600</b>

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