

 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 general 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 \$750 person / \$1,500 family, Non-Preferred \$2,000 person / \$4,000 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, services that require a copay, and additional services as indicated within this SBC.	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 \$7,500 person / \$15,000 family, for Non-Preferred providers \$9,000 person / \$18,000 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 ?	Prescription copays, 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 don't need a referral to see a specialist.	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	30% coinsurance	Deductible applies Non-Preferred.
	Specialist visit	\$40 copay	30% coinsurance	Deductible applies Non-Preferred.
	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. Deductible applies Non-Preferred.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	Deductible applies. Lab paid at 100% when performed by a Preferred freestanding facility.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	30% coinsurance	Deductible applies. Precertification is required for some diagnostic services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com	Generic drugs	\$10 copay retail \$20 copay mail order Any drug costing over \$999 is a 15% coinsurance.	Full-cost	Any maintenance medications must be filled at 90-day supplies through Caremark Mail Order or at a retail CVS. Otherwise, covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	\$40 copay retail \$80 copay mail order Any drug costing over \$999 is a 15% coinsurance.	Full-cost	
	Non-preferred drugs	\$70 copay retail \$140 copay mail order Any drug costing over \$999 is a 15% coinsurance.	Full-cost	
	Specialty drugs	Any drug costing over \$999 is a 15% coinsurance. Otherwise, see formulary to identify the specialty drug's tier (then see costs above)	Full-cost	Specialty medications must be filled exclusively through the Caremark Specialty Pharmacy, at 1-800-237-2767.

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 copay then 15% coinsurance	\$100 copay then 30% coinsurance	Deductible applies. Precertification is required for some outpatient surgeries.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Deductible applies. Precertification is required for some outpatient surgeries.
If you need immediate medical attention	Emergency room care	\$100 copay then 15% coinsurance	\$100 copay then 15% coinsurance	Non-emergency care not covered. Deductible applies.
	Emergency medical transportation	\$50 copay then 15% coinsurance	\$50 copay then 15% coinsurance	Deductible applies.
	Urgent care	\$20 copay	30% coinsurance	Deductible applies Non-Preferred.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay per day, then 15% coinsurance	\$200 copay per day, then 30% coinsurance	Deductible applies. Precertification is required. Maximum of \$1,000 copay liability per admission.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Deductible applies. Precertification is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay for Physician. 15% coinsurance for Facility.	30% coinsurance	Deductible applies. Services performed by Preferred physician not subject to deductible.
	Inpatient services	\$200 copay per day, then 15% coinsurance	\$200 copay per day, then 30% coinsurance	Deductible applies. Precertification is required. Maximum of \$1,000 copay liability per admission.
If you are pregnant	Office visits	\$20 copay	30% coinsurance	Deductible applies Non-Preferred. Precertification is required.
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	Deductible applies. Precertification is required.
	Childbirth/delivery facility services	\$200 copay per day, then 15% coinsurance	\$200 copay per day, then 30% coinsurance	Deductible applies. Precertification is required. Maximum of \$1,000 copay liability per admission.
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Precertification is required. Limited to 100 visits combined with visiting nurse benefits.
	Rehabilitation services	\$20 copay	30% coinsurance	Deductible applies Non-Preferred.
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	No Charge	30% coinsurance	Deductible applies Non-Preferred. Precertification is required. Limited to 120 days per year. Visiting skilled nursing care limited to 100 visits combined with Home health care.
	Durable medical equipment	15% coinsurance	30% coinsurance	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)	
	Hospice services	No Charge	30% coinsurance	Deductible applies Non-Preferred. Precertification is required.
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 .)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Dental care (Adult) 	<ul style="list-style-type: none"> • Hearing Aids • Infertility Treatment • Long Term Care 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Weight loss program
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Bariatric surgery • Chiropractic care 	<ul style="list-style-type: none"> • Most coverage provided outside the U.S. (See www.bcbglobalcore.com) • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing

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 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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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)] schwetzsch, kannsch 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 yIn7[ti'go, ata' hane' bee 1k1 i'iilyeed t'11 j77k'e bee n1 ah00t'i'. Koj8' hod77Inih 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](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$200
- Other [coinsurance](#) 15%

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	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$620
Coinsurance	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,590

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$200
- Other [coinsurance](#) 15%

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	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,070
Coinsurance	\$280
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$2,160

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

- The [plan's](#) overall [deductible](#) \$750
- [Specialist copayment](#) \$40
- Hospital (facility) [copayment](#) \$200
- Other [coinsurance](#) 15%

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	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$650
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,420

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