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 **$1,650** person / **$3,300** family, Non-Preferred **$5,000** person / **$10,000** 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	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 **$5,000** person / **$10,000** family, for Non-Preferred providers **$10,000** person / **$20,000** 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?	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	20% coinsurance	40% coinsurance	Deductible applies. Telemedicine: $15 copay per consultation (designated vendor only).
	Specialist visit	20% coinsurance	40% coinsurance	Deductible applies.
	Preventive care/screening/ immunization	No Charge	40% 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 to Non-Preferred. Limitations may apply.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some diagnostic services. No charge for lab/x-rays performed as part of ER or hospital care. There is a 20% reduction in benefits if preauthorization is not obtained.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	Retail: 30-day supply. Mail order: 90-day supply. Prior authorization is required for certain medications. If you receive a brand medication when there is a generic alternative, you will pay the difference in the cost of the medication in addition to the applicable brand cost-share.
	Preferred brand drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	
	Non-preferred drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	
	Specialty drugs	Retail and Mail Order: 20% coinsurance	Retail and Mail Order: 20% coinsurance	Prior authorization is required for certain medications. Specialty drugs will be paid at the formulary level, copays will vary. If you receive a brand medication when there is a generic alternative, you will pay the difference in the cost of the medication in addition to the applicable brand cost-share.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some outpatient surgeries. There is a 20% reduction in benefits if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Deductible applies.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Deductible applies.
	Urgent care	20% coinsurance	40% 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	Deductible applies.
	Inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Rehabilitation services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limited to 120 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained.
	Hospice services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required. There is a 20% reduction in benefits if preauthorization is not obtained. Limitations may apply.
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
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine eye care (Adult)
- 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
- Non-emergency care when traveling outside the U.S. (See www.bcbsglobalcore.com)
- Private-duty nursing
- Routine foot 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:

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

Spanish: ATENCIÓN: Si usted habla inglés, tiene a su disposición servicios de asistencia de idiomas sin costo. Llame al 1-844-864-4352(TTY: 711).

Chinese: 请注意：如果您说[中文]，则可以免费使用语言协助服务。请致电 1-844-864-4352（TTY：711）。

Hmong: LUS CEEB TOOM: Yog tias koj hais LUS HMOOB, ces yuav muaj kev pab cuam txhais lus pub dawb rau koj. Hu rau tus xov tooj 1-844-864-4352 (TTY: 711).

Vietnamese: CHÚ Ý: Nếu bạn nói [người việt nam], bạn sẽ được cung cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí. Gọi 1-844-864-4352(TTY: 711).

Somali: FIIRO GAAR AH: Haddii aad ku hadashid luuqada Soomaaliga, adeegyada caawinta luuqada, oo bilaash ah, ayaa laguu helayaa. Soo wac 1-844-864-4352 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском, вам доступны бесплатные услуги переводчика. Позвоните 1-844-864-4352 (TTY: 711).

Arabic: انتبه: إذا كنت تتحدث اللغة العربية، تم توفير خدمات المساعدة اللغوية مجانًا، اتصل بالرقم ١-٨٤٤-٣٥٢-١٧٠٦ (TTY: ٧١١).

French : ATTENTION : Si vous parlez le français, des services d'assistance linguistique gratuits, vous sont proposés. Appelez le 1-844-864-4352 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen ein kostenloser Sprachassistent zur Verfügung. Rufen Sie unter der Nummer 1-844-864-4352 (TTY: 711) an.

Amharic: ትኩረት፦ [አማርኛ] የሚናገሩ ከሆነ ከክፍያ ነፃ የሆነ የቋንቋ አገልግሎቶች በነጻ ያገኛሉ። 1-844-864-4352(TTY: 711) ላይ ደውሉ።

Korean: 주의: [한국어]를 사용하는 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 1-844-864-4352로 전화해주십시오. (TTY: 711).

Lao: ສິ່ງທີ່ຄວນຈື່: ຖ້າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອທາງດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ໄດ້ເສຍຄ່າ. ໂທ 1-844-864-4352 (TTY: 711).

Tagalog: PANSININ: Kung nagsasalita ka ng Tagalog, libre na available sa iyo ang mga serbisyo sa tulong sa wika. Tumawag sa 1-844-864-4352 (TTY: 711).

Navajo: Áhéhee': T'áá ał'nííł nigií bizaad yádaalłti'í nisin, yá'át'ééhá ánída'áł nisin, ákót'éego bee hóló̜, bizaad yádaalłti'í nisin dah nishłį̨, yaałtsoh da t'ááji'ígíí ashkii. 1-844-864-4352 t'áá baa yáshti'. (TTY: 711).

Khmer: ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសា [ខ្មែរ] មានផ្តល់សេវាកម្មជំនួយភាសាដែលឥតគិតថ្លៃជូនអ្នក។ ហៅទូរសព្ទទៅលេខ 1-844-864-4352 (TTY៖ 711)។

Italian: ATTENZIONE: Per coloro che parlano italiano, sono disponibili i servizi di assistenza linguistica gratuiti. Chiamare al numero 1-844-864-4352 (TTY: 711).

Guajarati: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો ભાષા સહાય સેવાઓ, તમારા માટે નિ:શુલ્ક ઉપલબ્ધ છે. 1-844-864-4352 (TTY: 711) પર કૉલ કરો.

Polish: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Zadzwoń pod numer 1-844-864-4352 (telefon tekstowy: 711).

Creole: ATANSYON: Si ou pale kreyòl, sèvis asistans lang yo gratis, e yo disponib pou ou. Rele nan 1-844-864-4352 (TTY: 711).

Portuguese: ATENÇÃO: Se você fala português, os serviços de assistência linguística, gratuitos, estão disponíveis para você. Ligue 1-844-864-4352 (TTY: 711).

Japanese: 注記：［日本語］話者向けの無料の言語支援サービスを利用できます。電話 1-844-864-4352（TTY：711）。

Farsi: توجه: اگر زبان شما فارسی است، خدمات کمک زبانی، به صورت رایگان در دسترس شما است. با شماره ۸۴۴-۳۵۲-۱۷۰۶ تماس بگیرید (TTY: ۷۱۱).

Urdu: متوجہ ہوں: اگر آپ اُردو بولتے ہیں، تو زبان کی معاونت کی خدمات، آپ کے لیے مفت دستیاب ہیں۔ ۱-۸۴۴-۳۵۲-۱۷۰۶ (TTY: ۷۱۱) پر کال کریں۔

Hindi: ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-864-4352 (TY: 711) पर कॉल करें।

Telugu: ధ్యాస పెట్టండి: మీరు తెలుగు మాట్లాడగలిగితే, భాషా సహాయక సేవలు మీకు ఉచితంగా లభిస్తాయి. 1-844-864-4352 (TTY: 711)కు కాల్ చేయండి.

Swahili: KUMBUKA: Iwapo unazungumza Kiswahili, utapata huduma za usaidizi wa lugha bila malipo. Piga simu kwa 1-844-864-4352 (TTY: 711).

Ojibwe: AMBE: Giishipin wii'wiidookaagooyan ji-noondam Ojibwemowin, ganoozhishinaam 1-844-864-4352 (TTY: 711) Gawain gidaw-diba'anziin.

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	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,650
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,910**

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

The plan's overall deductible	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,650
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,470**

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

The plan's overall deductible	$1,650
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,650
Copayments	$0
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,850**

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