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, visit www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). 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 www.healthcare.gov/sbc-glossary/ or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network providers $0 person / $0 family; For Out-of-Network providers $500 person / $1,000 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. Preventive care, Primary care services, Specialist services and Emergency room services are covered before you meet your 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 In-Network providers $1,500 person / $3,000 family; For Out-of-Network providers $3,000 person / $6,000 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-billing charges, and health care this plan doesn't cover.	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/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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
		In-Network Provider (You will pay the least)	Out-of-Network 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/Visit.	30% coinsurance.	Telemedicine (from designated telemedicine provider, www.ibx.com/findcarenow): $5/Visit.
	Specialist visit	$40/Visit.	30% coinsurance.	None
	Preventive care/screening/immunization	No charge.	30% coinsurance. Deductible does not apply.	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: $40/Visit. Blood Work: No charge.	30% coinsurance.	None
	Imaging (CT/PET scans, MRIs)	$40/Scan.	30% coinsurance.	Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/formulary3S.	Generic Drugs	Retail/Mail Order (1-30 days supply) $15/Fill. Mail Order (31-90 days supply) $30/Fill.	Retail (1-30 days supply) 30% reimbursement/ Mail Order not covered	Prior authorization required on some drugs; age and quantity limits may apply. 30-days supply limit on retail, and up to 90-day supply of maintenance drugs available at any participating retail pharmacy or mail order. Self-administered specialty drugs under pharmacy benefit limited to 30-days supply and may require use of preferred specialty pharmacy
	Preferred Brand	Retail/Mail Order (1-30 days supply) $35/Fill. Mail Order (31-90 days supply) $70/Fill.	Retail (1-30 days supply) 30% reimbursement/ Mail Order not covered	
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) $50/Fill. Mail Order (31-90 days supply) $100/Fill.	Retail (1-30 days supply) 30% reimbursement/ Mail Order not covered	
	Specialty Drugs	No charge.	30% coinsurance.	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home/office or outpatient facility. Self-administered specialty drugs that are covered under the pharmacy benefit follow the applicable retail prescription cost-share under the Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150/Visit.	30% coinsurance.	Precertification required. *See section General Information. 20% reduction in benefits for failure

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge.	30% coinsurance.	to pre-authorize out-of-network outpatient services or treatments.
If you need immediate medical attention	Emergency room care	$150/Visit.	Covered at In-Network level.	None
	Emergency medical transportation	No charge.	Covered at In-Network level.	
	Urgent care	$105/Visit.	30% coinsurance.	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/Day. Max of 5 Copayment(s)/Admission.	30% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment out-of-network.
	Physician/surgeon fees	No charge.	30% coinsurance.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $40/Visit. All Other Services: $40/Visit.	Office: 30% coinsurance. All Other Services: 30% coinsurance.	Precertification may be required. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Inpatient services	$150/Day. Max of 5 Copayment(s)/Admission.	30% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment out-of-network care.
If you are pregnant	Office visits	$25/Visit.	30% coinsurance.	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	No charge.	30% coinsurance.	
	Childbirth/delivery facility services	$150/Day. Max of 5 Copayment(s)/Admission.	30% coinsurance.	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
If you need help recovering or have other special health needs	Home health care	No charge.	30% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Rehabilitation services	$25/Visit visits 1-30 (after visit 30, $40/Visit).	30% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments.
	Habilitation services	$25/Visit visits 1-30 (after visit 30, $40/Visit).	30% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize services provided by a BlueCard PPO Provider or out-of-network outpatient services or treatments.
	Skilled nursing care	No charge.	30% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment for out-of-network care. 180 visits/Calendar Year. Visit limits combined in and out-of-network.
	Durable medical equipment	$40/Unit.	30% coinsurance.	Precertification required. 20% reduction in benefits for failure to pre-authorize out-of-network outpatient services or treatments.
	Hospice services	No charge.	30% coinsurance.	Precertification required. $1,000 member penalty for failure to pre-authorize inpatient services or treatment for out-of-network care.
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.)

- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY: 711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for

Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State Insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Pennsylvania Health Insurance Marketplace, visit www.Pennie.gov or call 1-844-844-8040.

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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans and church plans that are group health plans, contact us at 1-800-ASK-BLUE (TTY:711); if the coverage is insured, you may also contact the Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

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 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.

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** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **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	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$420**

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** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **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	$1,300
Coinsurance	$0
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** **$40**
- **Hospital (facility) copayment** **$150**
- **Other coinsurance** **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	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$500**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)