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?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	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 Referred providers $1,000 person / $2,000 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 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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(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
		Referred 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	$15/Visit.	Not covered.	Telemedicine (from designated telemedicine provider, www.ibx.com/findcarenow): $5/Visit.
	Specialist visit	$25/Visit.	Not covered.	PCP referral required.
	Preventive care/screening/immunization	No charge.	Not covered.	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)	No charge.	Not covered.	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	No charge.	Not covered.	PCP referral required. Precertification required for certain services. *See section General Information.
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.	Not covered.	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)	$50/Visit.	Not covered.	Precertification may be required. *See section General Information.
	Physician/surgeon fees	No charge.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Referred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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.	Not covered.	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)	$100/Day. Max of 5 Copayment(s)/Admission.	Not covered.	Precertification required.
	Physician/surgeon fees	No charge.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $25/Visit. All Other Services: No Charge	Office: Not covered. All Other Services: Not covered.	Precertification may be required.
	Inpatient services	$100/Day. Max of 5 Copayment(s)/Admission.	Not covered.	Precertification required.
If you are pregnant	Office visits	$25/Visit.	Not covered.	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.	Not covered.	
	Childbirth/delivery facility services	$100/Day. Max of 5 Copayment(s)/Admission.	Not covered.	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.	Not covered.	Precertification required.
	Rehabilitation services	No charge.	Not covered.	PCP referral required. Pre-authorization required for Speech Therapy.
	Habilitation services	No charge.	Not covered.	PCP referral required. Pre-authorization required for Speech Therapy.
	Skilled nursing care	No charge.	Not covered.	Precertification required. 180 visits/Calendar Year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Referred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge.	Not covered.	Precertification required for selected items. *See section General Information.
	Hospice services	No charge.	Not covered.	Precertification required.
If your child needs dental or eye care	Children's eye exam	$25/Visit.	Not covered.	Once every two years.
	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)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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
- Infertility treatment (limited to artificial insemination)
- Private-duty nursing
- 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. 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.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet.

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** **$25**
- **Hospital (facility) copayment** **$100**
- **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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$220**

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** **$25**
- **Hospital (facility) copayment** **$100**
- **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	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,020**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$25**
- **Hospital (facility) copayment** **$100**
- **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	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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)

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