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 1-866-607-6272. 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.dol.gov/ebsa/healthreform or call 1-866-607-6272 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$250**/individual; Maximum of 3 individual deductibles per family. Out-of-network: **$250**/individual; Maximum of 3 individual deductibles per 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. Vision, dental, and preventive 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?	Yes. Prescription drugs: **$200**/ individual. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: Medical: **$3,250**/individual; **$9,750**/family. Prescription drugs: **$3,350**/individual; **$3,450**/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, penalties for failure to obtain preauthorization, health care this plan doesn't cover, and out-of-network coinsurance.	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/individuals/find_provider/index.html or call 1-800-810-2583 for a list of PPO 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.

Important Questions	Answers	Why This Matters:
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
		PPO 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	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
	Specialist visit			
	Preventive care/screening/ Immunization	No charge. Deductible does not apply.	No charge.	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. Preventive services may be subject to age and frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	All testing must be done on an outpatient basis except when hospitalization is medically necessary.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	Retail: $10 copay/ prescription. Mail order: $20 copay/ prescription.	Not covered.	Subject to $200/individual prescription drug deductible. Mail order is mandatory for maintenance drugs after two retail fills. Retail limit: 30-day supply. Mail order limit: 90-day supply. No charge for ACA-required preventive generic drugs (e.g., contraceptives) or a brand name preventive drug if a generic is not medically appropriate. Preauthorization required for specialty drugs and may be required for other drugs.
	Formulary brand name drugs	Retail: 25% coinsurance ($25 min/$200 max). Mail order: 25% coinsurance ($50 min/ $400 max).	Not covered.	
	Non-formulary brand name drugs	Retail: 40% coinsurance ($50 min/$300 max). Mail order: 40% coinsurance ($100 min/$600 max).	Not covered.	
	Specialty drugs	Same as above, as applicable.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care	20% coinsurance.	20% coinsurance.	If you are admitted to a hospital, notification required to Independence Administrators (1-888-234-2393) within 48 hours of admission to avoid $500 penalty.
	Emergency medical transportation	20% coinsurance.	20% coinsurance.	None.
	Urgent care	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Preapproval required to avoid $500 penalty. Coverage limited to semi-private rate unless private room is medically necessary.
	Physician/surgeon fees	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
	Inpatient services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Preapproval required to avoid $500 penalty. Coverage limited to semi-private rate unless private room is medically necessary.
If you are pregnant	Office visits	Prenatal care: no charge. Postnatal care: 20% coinsurance.	Prenatal care: no charge. 30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Cost sharing does not apply for preventive services. Pregnancy of dependent child not covered except for certain preventive services required by law.
	Childbirth/delivery professional services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Not covered for dependent children. Coverage limited to semi-private rate unless private room is medically necessary.
	Childbirth/delivery facility services			

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Excludes charges for meals, custodial care, housekeepers, or services of a relative or member of the household.
	Rehabilitation services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Physical therapy: limit $100/visit. Must be provided by a licensed physical therapist.
	Habilitation services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Speech and vision habilitation services are not covered.
	Skilled nursing care	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
	Durable medical equipment	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	Rental charges covered only up to purchase price.
	Hospice services	20% coinsurance.	30% coinsurance (20% if you live more than 25 miles from a PPO provider).	None.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge.	One (1) eye exam/year.
	Children's glasses	No charge. Deductible does not apply.	No charge.	One (1) pair glasses or contacts/year.
	Children's dental check-up	No charge. Deductible does not apply.	No charge.	Two (2) routine dental exams/year. Two (2) cleanings/year. One (1) full mouth x-ray/year. Fluoride and sealants.

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 (except to repair the effect of an accidental injury or previous surgery and following mastectomy)
- Long-term care
- Routine foot care
- Weight loss programs (unless medically necessary)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery when medically necessary
- Chiropractic care (Limit: $62.50/visit)
- Dental care (Adult Age 18 & Over, Preventive Only) (10% coinsurance; Includes 2 exams/year, 2 cleanings/year, one full-mouth x-ray/year, fluoride and sealants)
- Hearing aids when prescribed by a physician
- Infertility treatment (50% coinsurance up to $5,000/cycle; lifetime limit: 2 cycles); in-network only
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult Age 19 & Over) (one set of contacts or glasses/year; 1 exam/year; maximum $250/family/year)

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: the Department of Labor's 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, call the plan at 1-866-607-6272. 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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-607-6272.

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	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Prescription drug deductible	$200

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*	$310
Copayments	$0
Coinsurance	$2,180
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$2,510**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Prescription drug deductible	$200

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*	$450
Copayments	$290
Coinsurance	$960
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,700**

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

The plan's overall deductible	$250
Specialist coinsurance	20%
Hospital (facility)	20%
Other coinsurance	20%

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*	$260
Copayments	$0
Coinsurance	$510
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$770**

***NOTE:** This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. The **plan** would be responsible for the other costs of these EXAMPLE covered services.