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/SGBooklet 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 Tier 1: $0 person / $0 family; For Tier 2 & 3: $6,000 person / $12,000 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 Participating providers $7,900 person / $15,800 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 limit 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.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2 or Tier 3. 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.

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 Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	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	$40/Visit.	$60/Visit. Deductible does not apply.	$70/Visit. Deductible does not apply.	Not covered.	Telemedicine MDLIVE ®: $40/Visit.
	Specialist visit	$80/Visit.	$120/Visit. Deductible does not apply.	$140/Visit. Deductible does not apply.	Not covered.	PCP referral required.
	Preventive care/ screening/ immunization	No charge.	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered.	Age and frequency schedules may apply. For colorectal cancer screening, your cost is $750/Procedure at a non-preventive plus provider. 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: $120/Visit. Blood Work: No charge.	X-Ray: $120/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	X-Ray: $120/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	Not covered.	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	$250/Scan.	$250/Scan. Deductible does not apply.	$250/Scan. Deductible does not apply.	Not covered.	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/ffm/formulary5v.	Generic Drugs	Retail/Mail Order (1-30 days supply) $15/Fill. Mail Order (31-90 days supply) $30/Fill.	Retail/Mail Order (1-30 days supply) $15/Fill. Mail Order (31-90 days supply) $30/Fill.	Retail/Mail Order (1-30 days supply) $15/Fill. Mail Order (31-90 days supply) $30/Fill.	Not covered. Retail (1-30 days supply) 30% reimbursement.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) prescription drug. Low-Cost Generics will be available at a reduced cost. This plan has a Preferred Pharmacy Network which excludes Walgreens and Rite-Aid. Mandatory Generic.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out of Network Provider (You will pay the most)	
	Preferred Brand	Retail/Mail Order (1-30 days supply) 50% coinsurance ($400 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($800 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance ($400 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($800 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance ($400 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($800 max/fill).	Not covered. Retail (1-30 days supply) 30% reimbursement.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) prescription drug. Low-Cost Generics will be available at a reduced cost. This plan has a Preferred Pharmacy Network which excludes Walgreens and Rite-Aid. Mandatory Generic.
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance ($500 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($1,000 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance ($500 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($1,000 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance ($500 max/fill). Mail Order (31-90 days supply) 50% coinsurance ($1,000 max/fill).	Not covered. Retail (1-30 days supply) 30% reimbursement.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) prescription drug. Low-Cost Generics will be available at a reduced cost. This plan has a Preferred Pharmacy Network which excludes Walgreens and Rite-Aid. Mandatory Generic.
	Specialty Drugs	Retail (1-30 days supply) 50% coinsurance ($1,000 max/fill).	Retail (1-30 days supply) 50% coinsurance ($1,000 max/fill).	Retail (1-30 days supply) 50% coinsurance ($1,000 max/fill).	Not covered.	This applies to self-administered specialty drugs covered under the prescription drug plan. Limited to a maximum 30 days supply. Prior authorization and/or additional dispensing limits may apply. Other specialty injectables and infusion therapy drugs may be covered under your medical benefits. *See section(s) prescription drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/Visit.	Subject to deductible and $750/Visit.	Subject to deductible and $1,250/Visit.	Not covered.	Precertification may be required. *See section General Information.
	Physician/surgeon fees	No charge.	5% coinsurance.	10% coinsurance.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out of Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$550/Visit.	$550/Visit. Deductible does not apply.	$550/Visit. Deductible does not apply.	Covered at in-network level.	None
	Emergency medical transportation	$200/Transport.	$200/Transport. Deductible does not apply.	$200/Transport. Deductible does not apply.	Covered at in-network level.	
	Urgent care	$100/Visit.	$100/Visit. Deductible does not apply.	$100/Visit. Deductible does not apply.	Not covered.	Your costs for urgent care are based on care received at a designated urgent care center or facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $900/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $1,300/Day. Max of 5 Copayment(s)/ Admission.	Not covered.	Precertification required.
	Physician/surgeon fees	No charge.	5% coinsurance.	10% coinsurance.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$80/Visit.	$80/Visit. Deductible does not apply.	$80/Visit. Deductible does not apply.	Not covered.	Precertification required.
	Inpatient services	$500/Day. Max of 5 Copayment(s)/ Admission.	$500/Day. Max of 5 Copayment(s)/ Admission. Deductible does not apply.	$500/Day. Max of 5 Copayment(s)/ Admission. Deductible does not apply.	Not covered.	
If you are pregnant	Office visits	$80/Visit.	$120/Visit. Deductible does not apply.	$140/Visit. Deductible does not apply.	Not covered.	Office visit cost share applies to the first OB visit only. Depending on the type of services, a copayment 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.	5% coinsurance.	10% coinsurance.	Not covered.	

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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out of Network Provider (You will pay the most)	
	Childbirth/delivery facility services	$500/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $900/Day. Max of 5 Copayment(s)/ Admission.	Subject to deductible and $1,300/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, a copayment 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.	5% coinsurance.	10% coinsurance.	Not covered.	Precertification required. 60 Visit(s)/Contract Year.
	Rehabilitation services	$80/Visit.	$80/Visit. Deductible does not apply.	$80/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical and Occupational Therapies: 30 visits combined/ Contract Year. Speech Therapy: 30 visits/ Contract Year.
	Habilitation services	$80/Visit.	$80/Visit. Deductible does not apply.	$80/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical and Occupational Therapies: 30 visits combined/ Contract Year. Speech Therapy: 30 visits/ Contract Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.
	Skilled nursing care	$250/Day. Max of 5 Copayment(s)/ Admission.	$250/Day. Max of 5 Copayment(s)/ Admission. Deductible does not apply.	$250/Day. Max of 5 Copayment(s)/ Admission. Deductible does not apply.	Not covered.	Precertification required. 120 Day(s)/ Contract Year.
	Durable medical equipment	50% coinsurance.	50% coinsurance. Deductible does not apply.	50% coinsurance. Deductible does not apply.	Not covered.	Precertification required for selected items. *See section General Information.
	Hospice services	No charge.	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered.	Precertification required.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out of Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge.	No charge.	No charge.	Not covered.	Once every Calendar Year.
	Children's glasses	No charge.	No charge.	No charge.	Not covered.	1 pair of glasses (lenses/frames) or contacts per Calendar Year.
	Children's dental check-up	No charge.	No charge.	No charge.	Not covered.	1 Exam(s)/Every 6 Months.

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

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.)		
• Bariatric surgery	• Cosmetic surgery	• Dental care (Adult)
• Hearing aids	• Long-term care	• Non-emergency care when traveling outside the U.S.
• Private-duty nursing	• 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.)		
• Abortion	• Acupuncture	• Chiropractic care
• Infertility treatment (only covered for artificial insemination)	• 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, you should contact your State Insurance regulator regarding 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 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: 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.
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 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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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

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** **$80**
- **Hospital (facility) copayment** **$500**
- **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	**$12,800**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$1,210**

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** **$80**
- **Hospital (facility) copayment** **$500**
- **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	**$7,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,560**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$80**
- **Hospital (facility) copayment** **$500**
- **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	**$1,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$640**

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.