



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](#), at [www.ibx.com/LGBooklet](http://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/](http://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 <a href="#">deductible</a> ?	\$0.	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For Referred <a href="#">Provider</a> \$1,500 person / \$3,000 family; for <a href="#">Out-of-network Provider</a> \$0 person / \$0 family.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.ibx.com/find_a_provider">www.ibx.com/find_a_provider</a> or call 1-800-ASK-BLUE (TTY:711) for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$20 <a href="#">Copayment (copay)</a> /visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	Not Covered	PCP <a href="#">referral</a> required.
	<a href="#">Preventive care/screening</a> /immunization	No Charge	Not Covered	Age and frequency schedules may apply. You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$20 <a href="#">copay</a> /test(X-Ray)/No Charge(Blood Work)	Not Covered	PCP <a href="#">referral</a> required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	\$40 <a href="#">copay</a> /test	Not Covered	PCP <a href="#">referral</a> required. Pre-certification required for certain services. *See section General Information.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ibx.com/preap">http://www.ibx.com/preap</a> proval	Generic drugs	\$10 <a href="#">copay</a> /\$25 <a href="#">copay</a>	Submit a direct claim form	Retail 30 day supply / Mail 31-90 day supply
	Preferred brand	\$30 <a href="#">copay</a> /\$75 <a href="#">copay</a>	Submit a direct claim form	Retail 30 day supply / Mail 31-90 day supply
	Non-preferred drugs	\$50 <a href="#">copay</a> /\$125 <a href="#">copay</a>	Submit a direct claim form	Retail 30 day supply / Mail 31-90 day supply
	<a href="#">Specialty drugs</a>	\$50 <a href="#">copay</a> /prescription fill	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 an office or outpatient facility. Self administered <a href="#">specialty drugs</a> follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior- authorization required. *See section Outpatient Services.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$100 <a href="#">copay</a> /visit	Not Covered	Pre-certification may be required. *See section General Information.
	Physician/surgeon fees	No Charge	Not Covered	Pre-certification may be required. *See section General Information.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$100 <a href="#">copay</a> /visit (waived if admitted)	Covered at in-network level	None
	<a href="#">Emergency medical transportation</a>	No Charge	Covered at in-network level	None
	<a href="#">Urgent care</a>	\$50 <a href="#">copay</a> /visit	Not Covered	Your costs for <a href="#">urgent care</a> are based on care received at a designated <a href="#">urgent care</a> center or facility, not your physician's office. Costs may vary depending on where you receive care.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 <a href="#">copay</a> /admission	Not Covered	Pre-certification required.
	Physician/surgeon fees	No Charge	Not Covered	Pre-certification required.
<b>If you need mental health, behavioral health, or substance</b>	Outpatient services	\$20 <a href="#">copay</a> /visit	Not Covered	Pre-certification required.

\*For more information about limitations and exceptions, see [plan](#) or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
<b>abuse services</b>	Inpatient services	\$250 <a href="#">copay</a> /admission	Not Covered	Pre-certification required.
<b>If you are pregnant</b>	Office visits	\$20 <a href="#">copay</a> /visit	Not Covered	Office visit cost share applies to the first OB visit only. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> 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	Office visit cost share applies to the first OB visit only. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> 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 facility services	\$250 <a href="#">copay</a> /admission	Not Covered	Office visit cost share applies to the first OB visit only. Depending on the type of services, a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	No Charge	Not Covered	Pre-certification required.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit	Not Covered	PCP <a href="#">referral</a> required. Physical/ Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit	Not Covered	PCP <a href="#">referral</a> required. Physical/ Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period.
	<a href="#">Skilled nursing care</a>	\$250 <a href="#">copay</a> /admission	Not Covered	Pre-certification required. 120 visits/ benefit period.
	<a href="#">Durable medical equipment</a>	30%	Not Covered	Pre-certification required for selected items. *See section General Information.
	<a href="#">Hospice services</a>	No Charge	Not Covered	Pre-certification required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40 <a href="#">Copay</a>	Not Covered	Once every contract year
	Children's glasses	Covered 100% on all Davis Collection of frames	Up to \$100 reimbursement to member	Once every contract year
	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](#).)

\*For more information about limitations and exceptions, see [plan](#) or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet)

- |   |  |   |
|---|--|---|
| <ul style="list-style-type: none"> <li>● Acupuncture</li> <li>● Hearing aids</li> <li>● Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>● Cosmetic Surgery</li> <li>● Infertility treatment</li> <li>● Routine foot care</li> </ul> | <ul style="list-style-type: none"> <li>● Dental care (adult)</li> <li>● Long-term care</li> <li>● Weight loss programs</li> </ul> |
|---|--|---|

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

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|---|---|--|
| <ul style="list-style-type: none"> <li>● Bariatric Surgery</li> <li>● Routine Eye care (adult)</li> </ul> | <ul style="list-style-type: none"> <li>● Chiropractic Care</li> </ul> | <ul style="list-style-type: none"> <li>● Private-duty nursing</li> </ul> |
|---|---|--|

**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](http://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](http://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](http://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: 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.* —————

**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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40	■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">copayment</a>	\$250	■ Hospital (facility) <a href="#">copayment</a>	\$250	■ Hospital (facility) <a href="#">copayment</a>	\$250
■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%	■ Other <a href="#">coinsurance</a>	0%
<b>This EXAMPLE event includes services like:</b> Specialist office visits ( <i>prenatal care</i> ) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests ( <i>ultrasounds and blood work</i> ) Specialist visit ( <i>anesthesia</i> )		<b>This EXAMPLE event includes services like:</b> Primary care physician office visits ( <i>including disease education</i> ) Diagnostic tests ( <i>blood work</i> ) Prescription drugs Durable medical equipment ( <i>glucose meter</i> )		<b>This EXAMPLE event includes services like:</b> Emergency room care ( <i>including medical supplies</i> ) Diagnostic test ( <i>x-ray</i> ) Durable medical equipment ( <i>crutches</i> ) Rehabilitation services ( <i>physical therapy</i> )	
<b>Total Example Cost</b>	<b>\$12,800</b>	<b>Total Example Cost</b>	<b>\$7,400</b>	<b>Total Example Cost</b>	<b>\$1,900</b>
<b>In this example, Peg would pay:</b>		<b>In this example, Joe would pay:</b>		<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$0	Deductibles	\$0	Deductibles	\$0
Copayments	\$300	Copayments	\$200	Copayments	\$200
Coinsurance	\$0	Coinsurance	\$500	Coinsurance	\$20
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$50	Limits or exclusions	\$4,300	Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$350</b>	<b>The total Joe would pay is</b>	<b>\$5,000</b>	<b>The total Mia would pay is</b>	<b>\$220</b>

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.

## Language Assistance Services

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意: 如果您讲中文, 您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** જો તમે જરાતી બોલતા હો, તો આ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે.

1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** قيوغلا قدع اسملا تامدخ نإف، تبيرعلا ةغللا ثاحتت تنك اذا: تمطوحم 1-800-275-2583. مقر ل لصتا. ن اجملا لكل تحاتم

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deitsch schwetzsch, kantscht du Hilf griegie in dei eegni Schpooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** यान दः यिद आप िह्दी बोलते ह तो आपके लिए मु त म भाषा सहायता सेवाएं उपल ध ह। कॉल कर 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考: 母国語が日本語の方は、言語アシスタンスサービス(無料)をご利用いただけます。1-800-275-2583へお電話ください。

**Persian (Farsi):**

تروص هبامجرت تامدخ، نيک يم تبص ي سراف رگا: هجوت 1-800-275-2583 در امشاد. دشاب ي م م هار فامش ي ا ر بن ا گيار ډير ي گس امد.

**Navajo:** D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh. H0d77lnih koj8' 1-800-275-2583.

**Urdu:**

م ت ف م ن ل ك پ ا و ت، س ي ب ي ت ل و ب ن ا ب ز و د ر ا پ ا ر گ ا: ه ج و ت 1-800-275-2583. ر ي ر ك ل ا ك ر ي ه ب ا ي ت س د ت ا م د خ ن و ا ع م

**Mon-Khmer, Cambodian:** សូមមេត្តា ចាប់--អមមណ្ឌ : ្របសិនេបើអនកនិយយក មន-ខែមា ឬក ខែមា ៖ ជំនួយជនកក នីមមនផ្តល់ជូនដល់ ៖ កអនកេ យតតតិកៃឡ្យ ទូរសពទេទេលេខ 1-800-275-2583។



## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan 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. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@1901market.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>.