

 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 \$2,000 person / \$4,000 family; For Out-of-Network providers \$5,000 person / \$10,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Preventive care is 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 \$6,750 person / \$13,500 family; For Out-of-Network providers \$10,000 person / \$20,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. In-Network: 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. Out-of-Network: If you have other family members in this plan , the overall family out-of-pocket limit must be 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 .



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	20% coinsurance .	50% coinsurance .	Telemedicine (from designated telemedicine provider , www.ibx.com/findcarenow): No charge.
	Specialist visit	20% coinsurance .	50% coinsurance .	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	50% coinsurance . Deductible does not apply.	Age and frequency schedules may apply. For colorectal cancer screening , your cost is \$750/Procedure(s) 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: 20% coinsurance . Blood Work: 20% coinsurance Freestanding facilities; 30% coinsurance Hospital-based facilities.	50% coinsurance .	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance .	50% 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/ffm/formulary5v .	Generic Drugs	Retail/Mail Order (1-30 days supply) \$20/Fill. Mail Order (31-90 days supply) \$40/Fill.	Not covered. Retail (1-30 days supply) 50% reimbursement.	Prior authorization required on some drugs; age and quantity limits may apply; 30 days supply limit on retail & 90 days supply on mail order for maintenance drugs. Low-Cost Generics will be available at a reduced cost. Value Formulary , not all drugs covered. Up to a 90-day supply of maintenance drugs available at Rite Aid or mail, same cost share.

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)	
	Preferred Brand	Retail/Mail Order (1-30 days supply) \$40/Fill. Mail Order (31-90 days supply) \$80/Fill.	Not covered. Retail (1-30 days supply) 50% reimbursement.	Prior authorization required on some drugs; age and quantity limits may apply; 30 days supply limit on retail & 90 days supply on mail order for maintenance drugs. Low-Cost Generics will be available at a reduced cost. Value Formulary , not all drugs covered. Up to a 90-day supply of maintenance drugs available at Rite Aid or mail, same cost share.
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) \$70/Fill. Mail Order (31-90 days supply) \$140/Fill.	Not covered. Retail (1-30 days supply) 50% reimbursement.	Prior authorization required on some drugs; age and quantity limits may apply; 30 days supply limit on retail & 90 days supply on mail order for maintenance drugs. Low-Cost Generics will be available at a reduced cost. Value Formulary , not all drugs covered. Up to a 90-day supply of maintenance drugs available at Rite Aid or mail, same cost share.
	Specialty Drugs	Retail (1-30 days supply) 50% coinsurance (\$500 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)	20% coinsurance .	50% coinsurance .	Precertification may be required. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Physician/surgeon fees	20% coinsurance .	50% coinsurance .	
If you need immediate medical attention	Emergency room care	20% coinsurance .	Covered at In-Network level.	None
	Emergency medical transportation	20% coinsurance .	Covered at In-Network level.	
	Urgent care	20% coinsurance .	50% 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.

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 have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance .	50% coinsurance .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Physician/surgeon fees	20% coinsurance .	50% coinsurance .	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: 20% coinsurance . All Other Services: 20% coinsurance .	Office: 50% coinsurance . All Other Services: 50% coinsurance .	Precertification may be required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Inpatient services	20% coinsurance .	50% coinsurance .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
If you are pregnant	Office visits	20% coinsurance .	50% 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	20% coinsurance .	50% coinsurance .	
	Childbirth/delivery facility services	20% coinsurance .	50% coinsurance .	
If you need help recovering or have other special health needs	Home health care	20% coinsurance .	50% coinsurance .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 60 visits/Contract Year combined in and out-of-network.
	Rehabilitation services	20% coinsurance .	50% coinsurance .	20% reduction in benefits for failure to precert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. All visit limits combined in and out-of-network.

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)	
	Habilitation services	20% coinsurance .	50% coinsurance .	20% reduction in benefits for failure to precert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 20 visits/Contract Year. All visit limits combined in and out-of-network.
	Skilled nursing care	20% coinsurance .	50% coinsurance .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 120 visits/Contract Year. Visit limits combined in and out-of-network.
	Durable medical equipment	20% coinsurance .	50% coinsurance .	Precertification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Hospice services	20% coinsurance .	50% coinsurance .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
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 .)			
• Bariatric surgery	• Hearing aids	• Routine eye care (Adult)	
• Cosmetic surgery	• Long-term care	• Routine foot care	
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Infertility treatment (limited to artificial insemination)	• Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
• Chiropractic care		

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? 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)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$10
Coinsurance	\$2,100

What isn't covered

Limits or exclusions	\$20
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The total Peg would pay is	\$4,130
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$800
Coinsurance	\$80

What isn't covered

Limits or exclusions	\$20
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The total Joe would pay is	\$2,900
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,000
Copayments	\$0
Coinsurance	\$200

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$2,200
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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)