Summary of Benefits and Coverage: What this Plan Covers & What it Costs

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ibx.com or by calling 1-800-ASK-BLUE.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers $4,400 person / $13,200 family.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.ibx.com/find_a_provider">www.ibx.com/find_a_provider</a> or call 1-800-ASK-BLUE for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes. Electronic referral required.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed in the Excluded Services &amp; Other Covered Services section. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-ASK-BLUE or visit us at www.ibx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.ibx.com or call 1-800-ASK-BLUE to request a copy.
- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a Referred Provider</td>
<td>an Out Of Network Provider</td>
</tr>
</tbody>
</table>
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $15 copayment | Not Covered | none-
| | Specialist visit | $20 copayment | Not Covered | PCP referral required-
| | Other practitioner office visit | No Charge | Not Covered | Spinal Manipulations covered up to 60 consecutive days per condition covered subject to significant improvement. PCP referral required-
| | Preventive care / screening / immunization | No Charge | Not Covered | Age and frequency schedules may apply-
| If you have a test | Diagnostic test (x-ray, blood work) | Covered No Charge when medically necessary | Not Covered | PCP referral required for x-rays. Requisition form required for lab work-
| | Imaging (CT/PET scans, MRIs) | Covered No Charge when medically necessary | Not Covered | Precertification required-
<p>| If you need drugs to treat your illness or condition | Generic drugs | Days 0-34 $10, Days 35-68 $20, Days 69-100 $30; Mail: Days 90+ $20 | Member pays out of pocket and submits for reimbursement, less the standard coinsurance | Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. Some drugs may be subject to prior authorization or quantity limit. |</p>
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<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred brand drugs</td>
<td>Days 0-34 $15, Days 35-68 $30, Days 69-100 $45; Mail: Days 90+ $30</td>
<td>Member pays out of pocket and submits for reimbursement, less the standard coinsurance. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. Some drugs may be subject to prior authorization or quantity limit.</td>
</tr>
<tr>
<td>More information about prescription drug coverage available at <a href="http://www.caremark.com">www.caremark.com</a></td>
<td>Non-preferred brand drugs</td>
<td>Days 0-34 $25, Days 35-68 $50, Days 69-100 $75; Mail: Days 90+ $50</td>
<td>Member pays out of pocket and submits for reimbursement, less the standard coinsurance. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. Some drugs may be subject to prior authorization or quantity limit.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>The applicable generic, preferred or non-preferred brand co-pays apply to Specialty medications dispensed through the prescription benefits.</td>
<td>Member pays out of pocket and submits for reimbursement, less the standard coinsurance. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at Caremark.com and use the Check Drug Coverage and Cost tool. Some drugs may be subject to prior authorization or quantity limit.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Emergency room services</td>
<td>$75 Copayment</td>
<td>$75 Copayment</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>No Charge</td>
<td>No Charge</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td><strong>Your Cost If You Use</strong></td>
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<tr>
<td>------------------------------</td>
<td>-------------------------------------------</td>
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<td>-----------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a Referred Provider</td>
<td>an Out Of Network Provider</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$25 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder outpatient services</td>
<td>$25 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder inpatient services</td>
<td>Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>Covered with a $20 copayment for first visit. Subsequent visits to your OB/GYN Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Habilitation services</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Covered No Charge when authorized by your Primary Care Physician</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your child needs dental or eye care</th>
<th>Eye exam</th>
<th>$20 copayment</th>
<th>Not Covered</th>
<th>Once every two contract years.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>------------------------------------------------none-----------</td>
</tr>
<tr>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td></td>
<td>------------------------------------------------none-----------</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acupuncture</td>
<td>- Bariatric surgery</td>
</tr>
<tr>
<td>- Hearing aids</td>
<td>- Chiropractic care</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S. (For details, see <a href="http://www.ibx.com">www.ibx.com</a>)</td>
<td>- Routine eye care (Adult)</td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
<td>- Dental care (Adult)</td>
</tr>
<tr>
<td>- Infertility treatment</td>
<td>- Long-term care</td>
</tr>
<tr>
<td>- Routine foot care</td>
<td>- Weight loss programs</td>
</tr>
</tbody>
</table>

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-671-5276. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:
Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan Pays:** $7,370
- **Patient Pays:** $170

#### Sample Care Costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient Pays

- **Deductibles:** $0
- **Copays:** $0
- **Coinsurance:** $0
- **Limits or exclusions:** $170
- **Total:** $170

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan Pays:** $4,440
- **Patient Pays:** $960

#### Sample Care Costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient Pays

- **Deductibles:** $0
- **Copays:** $30
- **Coinsurance:** $0
- **Limits or exclusions:** $930
- **Total:** $960
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✓ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✓ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles** and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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