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

Coverage for: FAMILY | **PlanType:** PPO

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.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers $0 person / $0 family. For non-participating providers $300 person / $600 family. Deductible may not apply to all services. See your cost information starting on page 2 for specific details.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	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.
Is there an out-of-pocket limit on my expenses?	Yes. For non-participating providers $2,000 person / $4,000 family.	The **out-of-pocket limit** is the most you could pay during a policy period for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Copayments, deductibles, premiums, out-of-network balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain precertification for services.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

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Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. See **www.ibx.com/find_a_provider** or call **1-800-ASK-BLUE** for a list f participating providers.	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 below for how this plan pays different kinds of **providers**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5.See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $10) 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 30% would be $300. 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.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copayment	30% , after deductible	----------none----------
	Specialist visit	$20 copayment	30% , after deductible	----------none----------
	Other practitioner office visit	$20 copayment	30% , after deductible	Restorative Services, including Chiropractic Care
	Preventive care/screening/immunization	No Charge	30% , no deductible	Routine Gynecological exam limited to 1 per benefit period; Nutrition counseling visits limited to 6 visits per benefit period. Nutrition counseling received out of network is subject to the deductible.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	$20 copayment(X-Ray)/No Charge(Blood Work)	30% , after deductible	There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.
	Imaging (CT/PET scans, MRIs)	$20 copayment	30% , after deductible	Precertification required; There is no cost for diagnostic services received in the Emergency Room or during a doctor's office visit.
If you need drugs to treat your illness or condition	Generic drugs	$10 for a 34-day supply at retail; $20 for a 100- day supply at mail	You pay the total cost; you will be reimbursed 80% of the average wholesale price of the drug, less applicable copay	Prescription drug benefits provided through Express Scripts. For more information about this benefit, log onto www.express-scripts.com
	Preferred brand drugs	$20 for a 34-day supply at retail; $40 for a 100-day supply at mail	You pay the total cost; you will be reimbursed 80% of the average wholesale price of the drug, less applicable copay	Prescription drug benefits provided through Express Scripts. For more information about this benefit, log onto www.express-scripts.com
	Non-preferred brand drugs	$40 for a 34-day supply at retail; $80 for a 100-day supply at mail	You pay the total cost; you will be reimbursed 80% of the average wholesale price of the drug, less applicable copay	Prescription drug benefits provided through Express Scripts. For more information about this benefit, log onto www.express-scripts.com
	Specialty drugs	No Charge when covered under medical plan; standard Rx copays apply under Prescription Drug plan	30% , after deductible when covered under medical plan; No Coverage under Prescription Drug	Prior-authorization required. A complete list of drugs requiring prior-authorization is available at www.ibx.com/preapproval
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copayment	30% , after deductible	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval

	Physician/surgeon fees	No Charge	30% , after deductible	Some outpatient surgeries require precertification. A complete list of surgeries requiring precertification is available at www.ibx.com/preapproval
If you need immediate medical attention	Emergency room services	Visits 1-4: $100 copayment; Visits 5-10: $200 copayment; Visits 11+: $500 copayment	Visits 1-4: $100 copayment, no deductible; Visits 5-10: $200 copayment, no deductible; Visits 11+: $500 copayment, no deductible	Waived if admitted
	Emergency medical transportation	No Charge	No Charge, no deductible (emergency); 30%, after deductible (non-emergency)	----------none----------
	Urgent care	$70 copayment	30% , after deductible	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.
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 per day (maximum of 5 copayments per admission)	30% , after deductible	In-Network: If your plan includes a copay for these services, your copay will be waived if you are readmitted to the hospital within 10 days of discharge. However, if your plan covers these services with coinsurance, your costs will not be waived if you are readmitted. Out-of- Network: 70 day limit per benefit period for all Inpatient Services, except Skilled Nursing Facility
	Physician/surgeon fee	No Charge	30% , after deductible	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not Covered through Independence BlueCross	Not Covered through Independence BlueCross	Coverage provided through mental health program. Call Fund Office for additional benefit information
	Mental/Behavioral health inpatient services	Not Covered through Independence Blue Cross	Not Covered through Independence Blue Cross	Coverage provided through mental health program. Call Fund Office for additional benefit information
	Substance abuse disorder outpatient services	Not Covered through Independence Blue Cross	Not Covered through Independence Blue Cross	Coverage provided through mental health program. Call Fund Office for additional benefit information

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-Of Network Provider	Limitations & Exceptions
	Substance abuse disorder inpatient services	Not Covered through Independence Blue Cross	Not Covered through Independence Blue Cross	Coverage provided through mental health program. Call Fund Office for additional benefit information
If you are pregnant	Prenatal and postnatal care	$10 copayment	30% , after deductible	Your cost is for first OB visit only.
	Delivery and all inpatient services	$75 per day (maximum of 5 copayments per admission)	30% , after deductible	Pre-notification requested
If you need help recovering or have other special health needs	Home health care	No Charge	30% , after deductible	----------none----------
	Rehabilitation services	$15 copayment [visits 1-30] $25 copayment [visits 31-60]	30% , after deductible	Precertification required for Speech Therapy.
	Habilitation services	$15 copayment [visits 1-30] $25 copayment [visits 31-60]	30% , after deductible	Precertification required for Speech Therapy.
	Skilled nursing care	No Charge	30% , after deductible	Precertification required.
	Durable medical equipment	$20 copayment	30% , after deductible	Precertification required for purchases (including repairs and replacements) over $500 and all rentals
	Hospice service	No Charge	30% , after deductible	----------none----------
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	----------none----------
	Glasses	Not Covered	Not Covered	----------none----------
	Dental check-up	Not Covered	Not Covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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	• Non-emergency care when travelling outside the U.S.
• Private-duty nursing	• Most coverage provided outside the United States. See **www.ibx.com**	

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:

If your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements, you may contact the U.S. Dept. of Labor Employee Benefits Security Administration at 866-444-3272, and following an appeal, you may have the right to bring a civil suit under Section 502(a) of the Act.

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** $7,240
- **Patient Pays** $300

Sample Care Costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays

Deductibles	$0
Copays	$100
Coinsurance	$0
Limits or exclusions	$200
Total	**$300**

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

- **Amount owed to providers:** $5,400
- **Plan Pays** $4,300
- **Patient Pays** $1,100

Sample Care Costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays

Deductibles	$0
Copays	$200
Coinsurance	$0
Limits or exclusions	$900
Total	**$1,100**

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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