


**Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services**

Independence  **Personal Choice PPO Silver Classic \$5,000/\$50/\$100/90%**

 **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](http://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/](http://www.healthcare.gov/sbc-glossary/) or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	For Participating <a href="#">providers</a> \$5,000 person / \$10,000 family; For Non-Participating <a href="#">providers</a> \$8,500 person / \$17,000 family.	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , Primary care services and <a href="#">Specialist</a> services are covered before you meet your <a href="#">deductible</a> .	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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	Yes. For pediatric dental services INN \$50 person. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	For Participating <a href="#">providers</a> \$9,100 person / \$18,200 family; For Non-Participating <a href="#">providers</a> \$25,000 person / \$50,000 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , balance-billing charges, 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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$50/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Telemedicine (from designated telemedicine <a href="#">provider</a> , <a href="http://www.ibx.com/findcarenow">www.ibx.com/findcarenow</a> ): No charge. <a href="#">Deductible</a> does not apply. Additional <a href="#">copayments</a> may apply when you receive other services at your <a href="#">provider's</a> office.
	<a href="#">Specialist</a> visit	\$100/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Additional <a href="#">copayments</a> may apply when you receive other services at your <a href="#">provider's</a> office.
	<a href="#">Preventive care/screening/immunization</a>	No charge. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> . <a href="#">Deductible</a> does not apply.	Age and frequency schedules may apply. For colorectal cancer <a href="#">screening</a> , your cost is \$750/Procedure(s) at a non-preventive plus <a href="#">provider</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. 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)	X-Ray: \$80/Visit Freestanding facilities. <a href="#">Deductible</a> does not apply; \$200/Visit Hospital-based facilities. <a href="#">Deductible</a> does not apply. Blood Work: No charge Freestanding facilities. <a href="#">Deductible</a> does not apply; 50% <a href="#">coinsurance</a> Hospital-based facilities.	50% <a href="#">coinsurance</a> .	None
	Imaging (CT/PET scans, MRIs)	\$200/Scan Freestanding facilities. <a href="#">Deductible</a> does not apply. \$400/Scan Hospital-based facilities. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.

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

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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.ibx.com/ffm/formulary5v">prescription drug coverage</a> is available at <a href="http://www.ibx.com/ffm/formulary5v">http://www.ibx.com/ffm/formulary5v</a>.</p>	Generic Drugs	Retail/Mail Order (1-30 days supply) \$20/Fill. Mail Order (31-90 days supply) \$40/Fill. <a href="#">Deductible</a> does not apply.	Not covered. Retail (1-30 days supply) 30% reimbursement. <a href="#">Deductible</a> does not apply.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) <a href="#">prescription drug</a> . Low-Cost Generics will be available at a reduced cost. This <a href="#">plan</a> has a Preferred Pharmacy <a href="#">Network</a> which excludes Walgreens. Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid. Mandatory Generic.
	Preferred Brand	Retail/Mail Order (1-30 days supply) \$85/Fill. Mail Order (31-90 days supply) \$170/Fill. <a href="#">Deductible</a> does not apply.	Not covered. Retail (1-30 days supply) 30% reimbursement. <a href="#">Deductible</a> does not apply.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) <a href="#">prescription drug</a> . Low-Cost Generics will be available at a reduced cost. This <a href="#">plan</a> has a Preferred Pharmacy <a href="#">Network</a> which excludes Walgreens. Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid. Mandatory Generic.
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) \$225/Fill. Mail Order (31-90 days supply) \$450/Fill. <a href="#">Deductible</a> does not apply.	Not covered. Retail (1-30 days supply) 30% reimbursement. <a href="#">Deductible</a> does not apply.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) <a href="#">prescription drug</a> . Low-Cost Generics will be available at a reduced cost. This <a href="#">plan</a> has a Preferred Pharmacy <a href="#">Network</a> which excludes Walgreens. Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid. Mandatory Generic.
	<a href="#">Specialty Drugs</a>	Retail (1-30 days supply) 50% <a href="#">coinsurance</a> (\$1,000 max/fill). <a href="#">Deductible</a> does not apply.	Not covered.	This applies to self-administered <a href="#">specialty drugs</a> covered under the <a href="#">prescription drug plan</a> . 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) <a href="#">prescription drug</a> .

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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$400/Visit. Freestanding facilities. \$750/Visit. Hospital-based facilities.	50% <a href="#">coinsurance</a> .	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	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$450/Visit.	Covered at In-Network level.	None
	<a href="#">Emergency medical transportation</a>	\$100/Transport. <a href="#">Deductible</a> does not apply.	Covered at In-Network level.	
	<a href="#">Urgent care</a>	\$125/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Office: \$100/Visit. <a href="#">Deductible</a> does not apply. All Other Services: \$100/Visit. <a href="#">Deductible</a> does not apply.	Office: 50% <a href="#">coinsurance</a> . All Other Services: 50% <a href="#">coinsurance</a> .	Precertification may be required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	Inpatient services	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
<b>If you are pregnant</b>	Office visits	\$50/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional <a href="#">copayments</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	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	

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

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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 60 Visit(s)/Contract Year combined in and out-of-network.
	<a href="#">Rehabilitation services</a>	PT/OT: \$100/Visit Freestanding facilities. <a href="#">Deductible</a> does not apply; \$130/Visit Hospital-based facilities. <a href="#">Deductible</a> does not apply. Speech: \$100/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Physical and Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 30 visits/Contract Year. All visit limits combined in and out-of-network.
	<a href="#">Habilitation services</a>	PT/OT: \$100/Visit Freestanding facilities. <a href="#">Deductible</a> does not apply; \$130/Visit Hospital-based facilities. <a href="#">Deductible</a> does not apply. Speech: \$100/Visit. <a href="#">Deductible</a> does not apply.	50% <a href="#">coinsurance</a> .	Physical and Occupational Therapies: 30 visits combined/Contract Year. Speech Therapy: 30 visits/Contract Year. All visit limits combined in and out-of-network. 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.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 120 Day(s)/Contract Year combined in and out-of-network.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a> .	50% <a href="#">coinsurance</a> .	Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.

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 your child needs dental or eye care	Children's eye exam	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	Once every Calendar Year.
	Children's glasses	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	1 pair of glasses (lenses/frames) or contacts per Calendar Year.
	Children's dental check-up	No charge. <a href="#">Deductible</a> does not apply.	Not covered.	1 Exam(s)/Every 6 Months.

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> <li>Long-term care</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot 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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> <li>Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Infertility treatment (only covered for artificial insemination)</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. See <a href="http://www.bcbsglobalcore.com">www.bcbsglobalcore.com</a></li> <li>Routine eye care (Adult)</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, 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](http://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](http://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.*

\*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/SGBooklet](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$100
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$5,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$600

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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<b>The total Peg would pay is</b>	<b>\$5,820</b>
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### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$100
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$2,400
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$2,620</b>
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### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$5,000
■ <a href="#">Specialist copayment</a>	\$100
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,900</b>
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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)