
 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, 1-888-494-4443. 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.com or call 1-888-494-4443 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$500 Individual / \$1,000 Family	If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>In-network preventive care</u> , and COVID-19 vaccinations are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your deductible.
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,850 Medical/\$3,000 Rx/Ind \$7,700 Medical/\$6,000 Rx/Family	If you have other family members on the <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges and health care this plan does not cover	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Visit www.MyIBTPAbenefits.com or call 1-833-242-3330 for a list of preferred providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware you <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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 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
		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	\$25 copayment per visit	\$25 copayment per visit	Balance Billing may apply to out-of-network services.
	Specialist visit	\$25 copayment per vis		work
	Preventive care/screening/immunization	\$0	\$0	preventive . Ask your doctor 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)	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	\$5 copayment / retail \$10 copayment / mail	Full cost of prescription – submit claim for reimbursement	Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions
	Preferred brand drugs	25% coinsurance / retail to maximum \$75/fill 25% coinsurance / mail to maximum \$150/fill	Full cost of prescription – submit claim for reimbursement	Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions, Mandatory Generic program.
	Non-preferred brand drugs	40% coinsurance / retail and mail order	Full cost of prescription – submit claim for reimbursement	Covers up to 30-day supply for retail; 31-90 day supply for mail order prescriptions, Mandatory Generic program
	Specialty drugs	25% coinsurance for preferred drugs; 40% coinsurance for non-preferred drugs	Full cost of prescription – submit claim for reimbursement	Limited injectable drugs ; some require pre-approval – Contact Express Scripts at 800-451-6245
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency
	Emergency medical transportation	20% coinsurance	20% coinsurance	Expenses must be incurred within 72 hours of onset of illness or injury – must be true emergency
	Urgent care	\$25 copayment per visit	\$25 copayment per visit	Balance Billing may apply to out-of-network services.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Requires pre-certification – contact IA at 1-888-234-2393
	Physician/surgeon fees	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copayment per visit	\$25 copayment per visit	Balance Billing may apply to out-of-network services.
	Inpatient services	20% coinsurance	20% coinsurance	Requires pre-certification – contact IA at 1-888-234-2393
If you are pregnant	Office visits	\$25 copayment per visit	\$25 copayment per visit	Pre-natal care only for dependent children. Charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	Members and spouses only. Charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Members and spouses only. Charges above allowed amount are your responsibility.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
	Rehabilitation services	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				services.
	Durable medical equipment	20% coinsurance	20% coinsurance	Balance Billing may apply to out-of-network services.
	Hospice services	20% coinsurance	20% coinsurance	Requires pre-certification – contact IA at 1-888-234-2393
If your child needs dental or eye care	Children’s eye exam	\$0		Limited to on exam and one pair of glasses per year
	Children’s glasses	\$0		
	Children’s dental check-up	\$0		No Limit for children

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](#).)

- | | | |
|---|--|--|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric Surgery • Chiropractic Care • Cosmetic Surgery | <ul style="list-style-type: none"> • Habilitation Services • Hearing aids • Infertility treatment • Long term care | <ul style="list-style-type: none"> • Non-emergency care outside U.S. • Routine foot care • Weight loss programs |
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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"> • Routine Dental care (separate plan – up to \$1,500 person/year) | <ul style="list-style-type: none"> • Routine Vision care (separate plan – up to \$250/person/year) |
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*To the extent required under the federal No Surprises Act, [out-of-network provider](#) services will be covered at the [copay](#) and [coinsurance](#) rates applicable to [in-network provider](#) services, and [balance billing](#) will not apply.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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,

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contact the plan at 1-888-494-4443. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 the 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.

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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](#) \$500
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$30
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,900

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$400
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist](#) [*cost sharing*] \$25
- Hospital (facility) [*cost sharing*] 20%
- Other [*cost sharing*] 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:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1000