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.

<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>$2,000 person / $4,000 family.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care is covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$5,600 person / $11,200 family.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. 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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, 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>Will you pay less if you use a network provider?</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 (TTY:711) for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>Telemedicine (from designated telemedicine provider, <a href="http://www.ibx.com/findcarenow">www.ibx.com/findcarenow</a>): No charge.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge. <strong>Deductible</strong> does not apply.</td>
<td>20% <strong>coinsurance</strong>. <strong>Deductible</strong> does not apply.</td>
<td>Age and frequency schedules may apply. 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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>Precertification required for certain services. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic Drugs</td>
<td>Retail/Mail Order (1-30 days supply) $10/Fill. Mail Order (31-90 days supply) $20/Fill.</td>
<td>Retail (1-30 days supply) 50% reimbursement/ Mail Order not covered</td>
<td>Prior authorization required on some drugs; age and quantity limits may apply. 30-days supply limit on retail, and up to 90-day supply of maintenance drugs available at any participating retail pharmacy or mail order. Self-administered specialty drugs under pharmacy benefit limited to 30-days supply and may require use of preferred specialty pharmacy</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand</td>
<td>Retail/Mail Order (1-30 days supply) $25/Fill. Mail Order (31-90 days supply) $50/Fill.</td>
<td>Retail (1-30 days supply) 50% reimbursement/ Mail Order not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non Preferred Drugs</td>
<td>Retail/Mail Order (1-30 days supply) $45/Fill. Mail Order (31-90 days supply) $90/Fill.</td>
<td>Retail (1-30 days supply) 50% reimbursement/ Mail Order not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home/office or outpatient facility. Self-administered specialty drugs that are covered under the pharmacy benefit follow the applicable retail prescription cost-share under the Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>No charge.</td>
<td>20% <strong>coinsurance</strong>.</td>
<td>Precertification may be required. *See section General Information. 20% reduction in benefits</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).*
<table>
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<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Physician/surgeon fees</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td></td>
<td>Emergency room care</td>
<td>No charge.</td>
<td>Covered at In-Network level.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>No charge.</td>
<td>Covered at In-Network level.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Office: No charge. All Other Services: No charge.</td>
<td>Office: 20% coinsurance. All Other Services: 20% coinsurance.</td>
<td>Precertification may be required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
</tbody>
</table>

*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Physical/Occupational Therapies: 60 visits combined/Contract Year. Speech Therapy: 60 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. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. Physical/Occupational Therapies: 60 visits combined/Contract Year. Speech Therapy: 60 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. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 180 visits/Contract Year. Visit limits combined in and out-of-network. Precertification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services. 180 visits/Contract Year. Visit limits combined in and out-of-network. Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge.</td>
<td>20% coinsurance.</td>
<td>Precertification required. 20% reduction in benefits for failure to precert out-of-network or BlueCard services.</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered.</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered.</td>
<td>None</td>
</tr>
</tbody>
</table>

**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.)

- Cosmetic surgery
- Long-term care
- Routine foot care

*For more information about limitations and exceptions, see plan or policy document at [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet).*
• Dental care (Adult)
• Routine eye care (Adult)
• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Routine eye care (Adult)
- Weight loss programs
- Dental care (Adult)
- Hearing aids
- Bariatric surgery
- Infertility treatment (covered for artificial insemination and assisted reproductive technology)
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- Acupuncture
- Hearing aids
- Bariatric surgery
- Infertility treatment (covered for artificial insemination and assisted reproductive technology)

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? If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- **Emergency room care** (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>$5,600</th>
<th>$2,800</th>
</tr>
</thead>
<tbody>
<tr>
<td>In this example, Peg would pay:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Cost Sharing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$2,000</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
<td>$700</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$20</td>
<td>$20</td>
<td>$0</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$2,030</td>
<td>$2,720</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

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)