



**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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or by calling 800-422-7617.

Important Questions	Answers		Why this Matters:
<p><b>What is the overall <u>deductible</u>?</b></p>	<p><b>In-Network:</b> Individual: <b>\$500</b> Family: <b>\$1,500</b></p>	<p><b>Out-of-Network:</b> Individual: <b>N/A</b> Family: <b>N/A</b></p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your plan document/SPD to see when the <b>deductible</b> 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 <b>deductible</b>.</p>
<p><b>Are there other <u>deductibles</u> for specific services?</b></p>	<p>Yes. \$100 RX Deductible.</p>		<p>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.</p>
<p><b>Is there an <u>out-of-pocket limit</u> on my expenses?</b></p>	<p><b>In-Network:</b> Individual: <b>\$3,500</b> Family: <b>\$7,000</b></p>	<p><b>Out-of-Network:</b> Individual: <b>N/A</b> Family: <b>N/A</b></p>	<p>The <b>out-of-pocket</b> limit is the most you could pay during a coverage period (usually one year) for your share of covered services. This limit helps you plan for health care expenses.</p>
<p><b>What is not included in the <u>out-of-pocket limit</u>?</b></p>	<p>Copayments, penalties for failing to follow precertification, amounts in excess of UCR, expenses not covered by the plan</p>		<p>Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b>.</p>
<p><b>Is there an overall annual limit on what the plan pays?</b></p>	<p>No Maximum.</p>		<p>The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.</p>

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

Important Questions	Answers	Why this Matters:
Does this plan use a <b>network of providers</b> ?	Yes. See <a href="http://www.magnacare.com">www.magnacare.com</a> for a list of participating providers. Yes. See <a href="http://www.multiplan.com">www.multiplan.com</a> for a list of participating providers.	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, preferred, or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <b>specialist</b> ?	No.	You can see the <b>specialist</b> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about <b>excluded services</b> .



- **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.

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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$30 copayment/visit	Not Covered	
	Specialist visit	\$50 copayment/visit	Not Covered	
	Other practitioner office visit	\$50 copayment/visit	Not Covered	
	Preventive care/screening/immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 10% Coinsurance	Not Covered	

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

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
	Imaging (CT/PET scans, MRIs)	Deductible then 10% Coinsurance	Not Covered	
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Generic drugs	\$15 Co-Pay Retail \$37.50 Co-Pay Mail Order	Not Covered	Generic drugs are not subject to the \$100 Pharmacy Deductible. Subject to the Medical Out of Pocket.
	Preferred brand drugs	\$40 Co-Pay Retail \$100 Co-Pay Mail Order	Not Covered	Subject to \$100 Pharmacy Deductible and Medical Out of Pocket.
	Non-preferred brand drugs	\$70 Co-Pay Retail \$210 Co-Pay Mail Order	Not Covered	Subject to \$100 Pharmacy Deductible and Medical Out of Pocket.
	Specialty drugs	Not Covered	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 copayment/visit	Not Covered	
	Physician/surgeon fees	\$100 copayment/visit	Not Covered	
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copayment/visit	\$200 copayment/visit	Copayment waived if admitted. Non-emergency not covered.
	Emergency medical transportation	Deductible then 10% Coinsurance	Deductible then 10% Coinsurance	
	Urgent care	\$50 copayment/visit	\$50 copayment/visit	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$1,500 copayment/admission to a maximum of \$2,500	Inetico Network Benefits Apply	Inetico Network Benefits Apply.
	Physician/surgeon fee	Deductible then 10% Coinsurance	Inetico Network Benefits Apply	Inetico Network Benefits Apply.

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

<b>Common Medical Event</b>	<b>Services You May Need</b>	<b>Your Cost If You Use an In-network Provider</b>	<b>Your Cost If You Use an Out-of-network Provider</b>	<b>Limitations &amp; Exceptions</b>
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copayment/visit	Not Covered	
	Mental/Behavioral health inpatient services	\$1,500 copayment/admission to a maximum of \$2,500	Inetico Network Benefits Apply.	Inetico Network Benefits Apply.
	Substance use disorder outpatient services	\$30 copayment/visit	Not Covered	
	Substance use disorder inpatient services	\$1,500 copayment/admission to a maximum of \$2,500	Inetico Network Benefits Apply.	Inetico Network Benefits Apply.
<b>If you are pregnant</b>	Prenatal and postnatal care	Covered 100%	Not Covered	
	Delivery and all inpatient services	\$1,500 copayment/admission to a maximum of \$2,500	Inetico Network Benefits Apply.	Inetico Network Benefits Apply.
<b>If you need help recovering or have other special health needs</b>	Home health care	\$50 copayment/visit	Not Covered	Limited to 40 visits per year.
	Rehabilitation services	\$50 copayment/visit	Not Covered	Limited to 90 visits for all therapies per year.
	Skilled nursing care	\$1,500 copayment/admission to a maximum of \$2,500	Not Covered	Limited to 30 days per year.
	Durable medical equipment	Deductible then 10% Coinsurance	Not Covered	Prior Authorization for DME over \$500.
	Hospice service	Deductible then 10% Coinsurance	Inetico Network Benefits Apply for Inpatient.	Inetico Network Benefits Apply for Inpatient.
<b>If your child needs dental or eye care</b>	Eye exam	Not Covered	Not Covered	Except as required under the ACA Preventive Care for Children.
	Glasses	Not Covered	Not Covered	-----none-----
	Dental check-up	Not Covered	Not Covered	Except as required under the ACA Preventive Care for Children.

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

### 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 (for rehabilitation purposes) | • Hearing Aids  | • Private Duty Nursing     |
| • Bariatric Surgery                         | • Infertility Treatment                               | • Routine Eye Care (Adult) |
| • Cosmetic Surgery                          | • Long-term Care                                      | • Routine Foot Care        |
| • Dental Care (Adult)                       | • Non-Emergency Care while Traveling outside the U.S. | • 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.)**

- Chiropractic Care

### 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 **800-422-7617**. 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](http://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](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact a plan representative at: **800-422-7617** or visit us at [www.ibatpa.com](http://www.ibatpa.com). 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](http://www.dol.gov/ebsa/healthreform).

Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Under "Internal Claims and Appeals and External Review", select *Consumer Assistance Programs* for contact information of those states currently offering programs to assist consumers in filing an appeal.

**Questions:** Call **800-422-7617** or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call **800-422-7617** to request a copy.

### **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.*—————

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

## 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 \$6,870
- Patient pays \$670

**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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$0
Copays	\$520
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$670</b>

These amounts assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not notified the plan, your costs may be higher. For more information, contact 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.com).

- Amount owed to providers: \$5,400
- Plan pays \$2,900
- Patient pays \$2,500

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$0
Copays	\$1,000
Coinsurance	\$0
Limits or exclusions	\$1,500
<b>Total</b>	<b>\$2,500</b>

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.com).

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.

**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.

**Questions:** Call 800-422-7617 or visit us at [www.ibatpa.com](http://www.ibatpa.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.dol.gov/esba/healthform](http://www.dol.gov/esba/healthform) or call 800-422-7617 to request a copy.