 **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 or by calling 878-222-4410

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0 Individual / \$0 Family	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	For network providers \$0 individual / \$0 family;	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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.
Does this plan use a <u>network of providers</u> ?	Yes. See https://www.multiplan.com/webcenter/portal/ProviderSearch for a list of network providers.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> 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 on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 to request a copy.



- **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 **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost (In Network Only)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$10 copay/visit excluding other services	
	Specialist visit	\$30 copay/visit excluding other services	
	Other practitioner office visit	\$30 copay/visit excluding other services	
	Preventive care/screening/immunization	No Charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	\$50 copay/visit \$500 maximum per year	Limited to a \$500 benefit per calendar year
	Imaging (CT/PET scans, MRIs)	\$75 copay/visit \$1,000 maximum per year	Limited to a \$1,000 benefit per calendar year
If you need drugs to treat your illness or condition More information	Generic drugs	\$5 copayment	Retail to a maximum \$50 benefit per prescription.

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 to request a copy.

L.J. Gonzer Associates: 001LJGE Copper Plan

Coverage Period: 01/01/2023 - 12/31/2032

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual/Family | Plan Type: Indemnity

about prescription drug coverage is available at www.optumrx.com	Preferred brand drugs	\$25 copayment	Retail to a maximum \$250 benefit per
	Non-preferred brand drugs	Not Covered	
	Specialty drugs	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	
	Physician/surgeon fees	Not Covered	
If you need immediate medical attention	Emergency room services	Not Covered	
	Emergency medical transportation	Not Covered	
	Urgent care	\$30 copayment/visit	

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 to request a copy.

L.J. Gonzer Associates: 001LJGE Copper Plan

Coverage Period: 01/01/2023 - 12/31/2032

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual/Family | **Plan Type:** Indemnity

Common Medical Event	Services You May Need	Your Cost	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	
	Physician/surgeon fee	Not Covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No Charge	Except as required under the ACA Preventive Care.
	Mental/Behavioral health inpatient services	Not Covered	
	Substance use disorder outpatient services	No Charge	Except as required under the ACA Preventive Care.
	Substance use disorder inpatient services	Not Covered	
If you are pregnant	Prenatal and postnatal care	Not Covered	Except as required under the ACA Preventive Care.
	Delivery and all inpatient services	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	
	Rehabilitation services	Not Covered	
	Habilitation services	Not Covered	
	Skilled nursing care	Not Covered	
	Durable medical equipment	Not Covered	
	Hospice service	Not Covered	
If your child needs dental or eye care	Eye exam	Not Covered	Except as required under the ACA Preventive Care for children.
	Glasses	Not Covered	
	Dental check-up	Not Covered	

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 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
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency Care when traveling outside the U.S.
- Private-duty Nursing
- 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.)

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 to request a copy.

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 **1-800-523-0582**. 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 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 more information, contact **1-800-523-0582**. 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/healthreform.

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 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.**

Language Access Services:

Group Health Plans must provide the SBC in a culturally and linguistically appropriate manner when the SBC is sent to an address in a county where 10% or more of the population are literate only in the same non-English language. The 10% or more determination is based on American Community Survey Data published by the U.S. Census Bureau and currently includes the following languages: Spanish, Tagalog, Chinese and Navajo.

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-523-0582]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-523-0582]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-523-0582]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-523-0582]

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 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 \$0**
- **Patient pays \$7,540**

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	\$0
Coinsurance	\$0
Limits or exclusions	\$7,540
Total	\$7,540

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$100**
- **Patient pays \$5,300**

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	\$0
Coinsurance	\$0
Limits or exclusions	\$5,300
Total	\$5,300

Questions: Call 878-222-4410 or visit us at 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 or call 878-222-4410 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 878-222-4410 or visit us at 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 or call 878-222-4410 to request a copy.