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 deductible?	**In-Network:** Individual: **$0** Family: **$0**	**Out-of-Network:** Individual: **$3,000** Family: **$6,000**	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document/SPD to see when the **deductible** 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 **deductible**.
	Does not apply to copayments, amounts in excess of UCR, services not covered, preventive care, office visits, emergency care, hospice care, home health care		
Are there other deductibles for specific services?	Yes. $100 RX Deductible.		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.
Is there an out–of–pocket limit on my expenses?	**In-Network:** Individual: **$2,500** Family: **$5,000**	**Out-of-Network:** Individual: **$9,000** Family: **$18,000**	The **out-of-pocket** 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.
What is not included in the out–of–pocket limit?	Copayments, penalties for failing to follow precertification, amounts in excess of UCR, expenses not covered by the plan		Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No Maximum.		The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Important Questions	Answers	Why this Matters:
Does this plan use a network of providers?	Yes. For professional and ancillary services. See www.magnacare.com for a list of participating providers. See www.multiplan.com fora list of participating providers. Inpatient / Facility services do not require any network.	If you use an in-network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in-network, preferred, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** 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 **excluded services**.

- **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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copayment/visit	Deductible then 30% Coinsurance	
	Specialist visit	$50 copayment/visit	Deductible then 30% Coinsurance	
	Other practitioner office visit	$50 copayment/visit	Deductible then 30% Coinsurance	

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
	Preventive care/screening/immunization	No Charge	Deductible then 30% Coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	$100 copayment/visit	Deductible then 30% Coinsurance	
	Imaging (CT/PET scans, MRIs)	$100 copayment/visit	Deductible then 30% Coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	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	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copayment/visit	Deductible then 30% Coinsurance	Requires precertification.
	Physician/surgeon fees	$100 copayment/visit	Deductible then 30% Coinsurance	
If you need immediate medical attention	Emergency room services	$200 copayment/visit		Copayment waived if admitted. Non-emergency not covered. No network required.
	Emergency medical transportation	Covered 100%	Covered 100%	Covered at the in-network benefit level if a true emergency.
	Urgent care	$50 copayment/visit	$50 copayment/visit	

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 have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copayment/admission to a maximum of $2,500		Requires precertification. No network required.
	Physician/surgeon fee	$350 copayment/visit		No network required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copayment/visit	Deductible then 30% Coinsurance	
	Mental/Behavioral health inpatient services	$1,500 copayment/admission to a maximum of $2,500		Requires precertification. No network required.
	Substance use disorder outpatient services	$30 copayment/visit	Deductible then 30% Coinsurance	
	Substance use disorder inpatient services	$1,500 copayment/admission to a maximum of $2,500		Requires precertification. No network required.
If you are pregnant	Prenatal and postnatal care	Covered 100%	Deductible then 30% Coinsurance	
	Delivery and all inpatient services	$1,500 copayment/admission to a maximum of $2,500		Requires precertification for extended stay. No network required.
If you need help recovering or have other special health needs	Home health care	$50 copayment/visit	Deductible then 30% Coinsurance	Limited to 40 visits per year.
	Rehabilitation services	$50 copayment/visit	Deductible then 30% Coinsurance	Limited to 90 visits for all therapies per year.
	Skilled nursing care	$1,500 copayment/admission to a maximum of $2,500		Limited to 30 days per year. No network applies. Requires precertification.
	Durable medical equipment	Covered 100%	Deductible then 30% Coinsurance	Prior Authorization for DME over $500.

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
	Hospice service	$1,500 copayment/admission to a maximum of $2,500/ Outpatient: Covered 100%		No network applies. Inpatient requires precertification.
If your child needs dental or eye care	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.

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)
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-term Care
- Non-Emergency Care while 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.)**

- 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 878-222-4410. 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 questions about your rights, this notice, or assistance, you can contact a plan representative at: 878-222-4410 or visit us at 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.

Additionally, a consumer assistance program may be available in your state to help you with your appeal. Visit 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.

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.

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
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$520
Coinsurance	$0
Limits or exclusions	$150
Total	**$670**

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.

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

- **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
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,000
Coinsurance	$0
Limits or exclusions	$1,500
Total	**$2,500**

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.

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.