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, see www.ibatpa.com. 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 1-878-222-4410 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network:** **$0** individual / **$0** family **Out-of-Network:** **$3,000** individual / **$6,000** family	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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible (embedded). Prescription drugs are subject to separate deductible.
Are there services covered before you meet your deductible?	Yes. All In-Network services are covered with no deductible.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$100** for Prescription Drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**In-Network:** **$2,500** individual / **$5,000** family **Out-of-Network:** **$9,000** individual / **$18,000** family	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 (embedded). Prescription drug cost-share applies to the medical out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. For professional providers in the NY/NJ area see www.magnacare.com. For professional providers for non-NY/NJ members see www.multiplan.com. You may also	This plan uses a professional 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.

	call **1-878-222-4410** for a list of participating providers. There is no network for facilities.	
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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	$30 copay/visit	Deductible then 30% coinsurance	
	Specialist visit	$50 copay/visit	Deductible then 30% coinsurance	
	Preventive care/screening/immunization	No charge	Deductible then 30% coinsurance	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.
If you have a test	Diagnostic test (x-ray, blood work)	$100 copay/visit	Deductible then 30% coinsurance	Diagnostic testing during an office visit will be covered at 100% after the applicable office visit copay.
	Imaging (CT/PET scans, MRIs)	$100 copay/visit	Deductible then 30% coinsurance	Pre-certification is required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.OptumRX.com	Generic drugs	Retail: $15 copay/prescription Mail Order: $37.50 copay/prescription	Not covered	Generic drugs are not subject to the $100 Prescription deductible.
	Preferred brand drugs	Retail: $40 copay/prescription Mail Order: $100 copay/prescription	Not covered	Prescription deductible of $100 applies prior to copay.
	Non-preferred brand drugs	Retail: $70 copay/prescription Mail Order: $210 copay/prescription	Not covered	Prescription deductible of $100 applies prior to copay.
	Specialty drugs	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit		Pre-certification is required. There is no network for facilities.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	$100 copay/visit	Deductible then 30% coinsurance	Surgery in an office setting will apply the applicable PCP/Specialist office visit copay.
If you need immediate medical attention	Emergency room care	$200 copay/visit		ER copay will be waived if admitted.
	Emergency medical transportation	No charge		
	Urgent care	$50 copay/visit		
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,500 copay/admission		Pre-certification is required. There is no network for facilities.
	Physician/surgeon fee	Surgeon: $350 copay/visit Physician visits: No charge	Deductible then 30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Deductible then 30% coinsurance	Includes Office visits, Partial Hospitalization, and Intensive Outpatient Treatment.
	Inpatient services	$1,500 copay/admission		Pre-certification is required. There is no network for facilities.
If you are pregnant	Office visits	No charge	Deductible then 30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of service, a copayment may apply.
	Childbirth/delivery professional services	No charge	Deductible then 30% coinsurance	
	Childbirth/delivery facility services	$1,500 copay/admission		Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay in order to avoid a penalty. There is no network for facilities.
If you need help recovering or have other special health needs	Home health care	$50 copay/visit	Deductible then 30% coinsurance	Pre-certification is required. Limited to 40 visits per year.
	Rehabilitation services	$50 copay/visit	Deductible then 30% coinsurance	Limited to 90 visits per year combined with Physical, Occupational, and Speech therapies.
	Habilitation services	$50 copay/visit	Deductible then 30% coinsurance	Limited to 90 visits per year combined with Physical, Occupational, and Speech therapies.
	Skilled nursing care	$1,500 copay/admission		Limited to 30 days per year. Pre-certification is required. There is no network for facilities.
	Durable medical equipment	No charge	Deductible then 30% coinsurance	Pre-certification is required for items over $500 purchase price.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	$1,500 copay/admission		Pre-certification is required for inpatient and home hospice.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	If performed during a routine well visit with pediatrician following ACA guidelines it is covered at no charge.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	If performed during a routine well visit with pediatrician following ACA guidelines it is covered at no charge.

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.)

- Acupuncture
- Bariatric surgery
- 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.)

- Chiropractic Care (limited to 30 visits per year)

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: Department of Labor's 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 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 the plan at 1-878-222-4410. 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.

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	$0
Specialist *[copay]*	$50
Hospital (facility) *[copay]*	$1,500
Other *[coinsurance]*	0%
This EXAMPLE event includes services like:	
Primary care physician 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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Peg would pay is	**$1,500**

Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
The plan's overall deductible	$0
Specialist *[copay]*	$50
Hospital (facility) *[copay]*	$1,500
Other *[coinsurance]*	0%
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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Joe would pay is	**$360**

Mia's Simple Fracture (in-network emergency room visit and follow up care)	
The plan's overall deductible	$0
Specialist *[copay]*	$50
Hospital (facility) *[copay]*	$1,500
Other *[coinsurance]*	0%
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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$
The total Mia would pay is	**$700**

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