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.ibxtpa.com/students or by calling 1-888-547-5080.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Preferred **$0** person, Non-Preferred **$500** person.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document 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**.
Are there other deductibles for specific services?	No.	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?	Yes. For Preferred providers **$1,000** person, for Non-Preferred providers **$3,000** person. Prescription Out-of-Pocket limit: **$5,500**.	The **out-of-pocket limit** 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 out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.	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.	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 network of providers?	Yes. See **www.ibxtpa.com/students or call: 1-888-547-5080** for a list of **Preferred providers**.	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 don't need a referral to see a specialist.	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 on the Excluded Services & Other Covered Services page. See your policy or plan document 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 **Preferred providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay	40% coinsurance	Deductible applies.
	Specialist visit	$30 copay	40% coinsurance	Deductible applies.
	Other practitioner office visit	20% coinsurance for chiropractor	40% coinsurance for chiropractor	Maximum of 20 visits per plan year. Deductible applies.
	Preventive care/ screening/immunization	No Charge	40% coinsurance	Deductible applies.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some diagnostic services.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some diagnostic services.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ibxtpa.com/students	Generic drugs	$15 copay retail $30 copay mail order	$15 copay retail $30 copay mail order	Retail: 30-day supply. Mail Order: 90-day supply.
	Preferred brand drugs	$30 copay retail $60 copay mail order	$30 copay retail $60 copay mail order	Retail: 30-day supply. Mail Order: 90-day supply.
	Non-preferred brand drugs	$50 copay retail $100 copay mail order	$50 copay retail $100 copay mail order	Retail: 30-day supply. Mail Order: 90-day supply.
	Specialty drugs	$50 copay retail $100 copay mail order	$50 copay retail $100 copay mail order	Retail: 30-day supply. Mail Order: 90-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required for some outpatient surgeries.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required for some outpatient surgeries.
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Deductible applies.
	Emergency medical transportation	20% coinsurance	40% coinsurance	Deductible applies.
	Urgent care	20% coinsurance	40% coinsurance	Deductible applies.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Preauthorization is required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance for facility / $15 copay for physician	40% coinsurance	Deductible applies except for physician.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Substance use disorder outpatient services	20% coinsurance for facility / $15 copay for physician	40% coinsurance	Deductible applies except for physician.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Deductible applies.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 120 days per plan year. Deductible applies. Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Physical, Occupational & Speech Therapies are limited to 60 visits per plan year combined. Deductible applies. Preauthorization is required.
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 120 days per plan year. Deductible applies. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.
	Hospice service	20% coinsurance	40% coinsurance	Deductible applies. Preauthorization is required.
If your child needs dental or eye care	Eye exam	Student & dependents age 0 to 18: No Charge. Students age 19 and older: Davis Vision Discount Program.	Not Covered	Students & dependents age 0 to 18: 1 exam per calendar year. Students age 19 and older: Davis Vision Discount Program.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
	Glasses	Student & dependents age 0 to 18: No Charge. Students age 19 and older: Davis Vision Discount Program.	Not Covered	Students & dependents age 0 to 18: 1 pair per calendar year. Contact lenses must be medically necessary with prior approval. Students age 19 and older: Davis Vision Discount Program.
	Dental check-up	Student & dependents age 0 to 18: No Charge. Student & dependents age 19 and older: Not Covered.	Not Covered	Students & dependents age 0 to 18: Basic benefits including X-rays, cleaning, and 1 exam every 6 months. Covers medically necessary Orthodontics. Dental benefits provided by United Concordia. For dental providers visit www.unitedconcordia.com.

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
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Long Term Care
- Weight loss program

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
- Infertility Treatment (Diagnosis & Surgical Correction Only)
- Most coverage provided outside the U.S. (See BlueCard Worldwide® at www.ibxtpa.com/find_a_doctor)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Outpatient Only; 360 hours per plan year)
- Routine eye care (Adult)
- Routine foot care (Medical Necessity Only)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-ASK-BLUE. You may also contact your state insurance department at The Pennsylvania Department of Insurance, 1326 Strawberry Square, Harrisburg, Pa. 17111 (877) 881-6388 or at www.insurance.pa.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: 1-888-547-5080 or www.ibxtpa.com/students. 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. You may also contact your state insurance department at The Pennsylvania Department of Insurance, 1326 Strawberry Square, Harrisburg, Pa. 17111 (877) 881-6388 or at www.insurance.pa.gov.

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:

English: For assistance in English, call 1-888-547-5080.
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-5080.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-5080.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-888-547-5080.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-547-5080.

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** $6,390
- **Patient pays** $1,150

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	$1,000
Limits or exclusions	$150
Total	**$1,150**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,320
- **Patient pays** $1,080

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	$720
Coinsurance	$280
Limits or exclusions	$80
Total	**$1,080**

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.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

Questions: Call 1-888-547-5080 or visit us at www.ibxtpa.com/students. 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/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-888-547-5080 to request a copy.

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