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, visit www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). 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 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network providers $420 person / $630 person and one dependent / $840 family.	You must pay all of the costs from providers up to the deductible amount before this plan begins to pay the overall EE Only, EE/Child or Family (Incl. EE/SP/DP & EE/Children & Family) deductible must be meet before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary care services, Specialist services and Emergency room services are covered before you meet your 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network providers $1,735 person / $2,575 person and one dependent / $3,465 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If enrolled in this plan, the overall EE Only, EE/Child or Family (Incl. EE/SP/DP & EE/Children & Family) out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, precertification penalties, and health care this plan doesn't 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	This plan uses a 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

OMB control number: 0938-1146/Expiration date: 05/31/2026

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

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	$25/Visit. Deductible does not apply.	Not covered.	Telemedicine (from designated telemedicine provider, www.ibx.com/findcarenow): No charge. Deductible does not apply.
	Specialist visit	$50/Visit. Deductible does not apply.	Not covered.	None
	Preventive care/screening/immunization	No charge. Deductible does not apply.	Not covered.	Age and frequency schedules may apply. 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)	X-Ray: 15% coinsurance. Blood Work: No charge. Deductible does not apply.	Not covered.	None
	Imaging (CT/PET scans, MRIs)	$100/Scan and 15% coinsurance.	Not covered.	PCP referral required. Precertification required for certain services. *See section General Information.
If you need drugs to treat your illness or condition More information about pr http://www.ibx.com/provid	Generic Drugs	Retail/Mail Order (1-30 days supply) 15% coinsurance. Mail Order (31-90 days supply) 15% coinsurance. Deductible does not apply.	Not covered.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. Self-administered specialty drugs under pharmacy benefit limited to 30 days supply and may require use of preferred specialty pharmacy. *See section(s) prescription drug. Premium Formulary, not all drugs covered. Mandatory Generic. CVS90 Saver Plus mandatory for maintenance drugs through CVS or mail, same cost share.
	Preferred Brand	Retail/Mail Order (1-30 days supply) 35% coinsurance. Mail Order (31-90 days supply) 35% coinsurance. Deductible does not apply.	Not covered.	
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance. Mail Order (31-90 days supply) 50% coinsurance. Deductible does not apply.	Not covered.	
	Specialty Drugs	15% coinsurance.	Not covered.	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in a home/office or

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)	
				outpatient facility. Self-administered specialty drugs that are covered under the pharmacy benefit follow the applicable retail prescription cost-share under the Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance.	Not covered.	Precertification may be required. *See section General Information.
	Physician/surgeon fees	15% coinsurance.	Not covered.	
If you need immediate medical attention	Emergency room care	$300/Admission. Deductible does not apply.	Covered at In-Network level.	None
	Emergency medical transportation	15% coinsurance.	Covered at In-Network level.	
	Urgent care	$50/Visit. Deductible does not apply.	Not covered.	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250/Admission and 15% coinsurance.	Not covered.	Precertification required.
	Physician/surgeon fees	15% coinsurance.	Not covered.	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20/Visit. Deductible does not apply. All Other Services: $20/Visit. Deductible does not apply.	Office: 50% after deductible. All Other Services: 50% after deductible.	Precertification may be required.
	Inpatient services	No charge.	Not covered.	Precertification required.
If you are pregnant	Office visits	15% coinsurance.	Not covered.	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	15% coinsurance.	Not covered.	
	Childbirth/delivery facility services	$250/Admission and 15% coinsurance.	Not covered.	
If you need help recovering or have other special health needs	Home health care	15% coinsurance.	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services.
	Rehabilitation services	$40/Visit. Deductible does not apply.	Not covered.	20% reduction in benefits for failure to precert BlueCard services. Physical/Occupational/Speech Therapies: 60

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)	
				visits combined/Calendar Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.
	Habilitation services	$40/Visit. Deductible does not apply.	Not covered.	20% reduction in benefits for failure to precert BlueCard services. Physical/Occupational/Speech Therapies: 60 visits combined/Calendar Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.
	Skilled nursing care	15% coinsurance.	Not covered.	Precertification required. 20% reduction in benefits for failure to precert BlueCard services. 120 visits/Calendar Year.
	Durable medical equipment	No charge after deductible	Not covered.	Precertification required for selected items. *See section General Information.
	Hospice services	15% coinsurance.	Not covered.	Precertification required.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	$40 reimbursement.	Once every two years.
	Children's glasses	No charge. Deductible does not apply.	$50 reimbursement.	None
	Children's dental check-up	Not covered.	Not covered.	None

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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY: 711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State Insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Pennsylvania Health Insurance Marketplace, visit www.Pennie.gov or call 1-844-844-8040.

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: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans and church plans that are group health plans, contact us at 1-800-ASK-BLUE (TTY:711); if the coverage is insured, you may also contact the Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

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 Minimum Value Standards?
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	$420
Specialist copayment	$50
Hospital (facility) copayment	$300
Other coinsurance	15%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,730**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$420
Copayments	$300
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,740**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$420
Specialist copayment	$50
Hospital (facility) copayment	$300
Other coinsurance	15%

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	$200
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$420
Specialist copayment	$50
Hospital (facility) copayment	$300
Other coinsurance	15%

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	**$2,830**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$420
Copayments	$500
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,020**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. Devereux provides a premium decrease if participants meet wellness program target in the previous year. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)

The plan would be responsible for the other costs of these EXAMPLE covered services.