



**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.ibatpa.com](http://www.ibatpa.com) or by calling 800-422-7617.

Important Questions	Answers		Why this Matters:
What is the overall <u>deductible</u> ?	<b>In-Network:</b> Individual: <b>\$900</b> Family: <b>\$1,800</b>	<b>Out-of-Network:</b> Individual: <b>\$3,000</b> Family: <b>\$6,000</b>	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 plan document/SPD 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> .
	Applies to the Out of Pocket Maximum.		
Are there other <u>deductibles</u> 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 <u>out-of-pocket limit</u> on my expenses?	<b>In-Network:</b> Individual: <b>\$3,000</b> Family: <b>\$6,000</b>	<b>Out-of-Network:</b> Individual: <b>\$6,000</b> Family: <b>\$12,000</b>	The <u>out-of-pocket</u> 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 <u>out-of-pocket limit</u> ?	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 <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.cigna.com">www.cigna.com</a> for a list of participating providers.		If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, preferred, or participating for <b>providers</b> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
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 below (see Excluded Services & Other Covered Services). See your plan document/SPD for additional information about <u>excluded services</u> .

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- **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 <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$40 copayment/visit	Deductible then 40% coinsurance	
	Specialist visit	\$80 copayment/visit	Deductible then 40% coinsurance	
	Chiropractic Services	\$80 copayment/visit	Deductible then 40% coinsurance	Limited to 30 visits per calendar year. Combined in and out of network.
	Preventive care/screening/immunization	No Charge	Deductible then 40% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Applies for all services rendered at an Office Visit, Free Standing Facility and Outpatient Hospital Setting
	Imaging (CT/PET scans, MRIs)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Applies for all services rendered at an Office Visit, Free Standing Facility and Outpatient Hospital Setting
If you need drugs to treat your illness or condition More information about <b>prescription drug</b>	Generic drugs	Retail: \$10 co-payment / prescription Mail Order: \$25 co-payment / prescription		Retail: Covers up to a 30-day supply (retail prescriptions).
	Preferred brand drugs	Retail: 30% (min. \$25/ max. \$50) Mail Order: 30% (min. \$62.50/ max. \$125)		Mail Order: Covers up to a 90-day supply (mail order prescriptions).
	Non-preferred brand drugs	Retail: 45% (min. \$40/ max. \$80) Mail Order: 45% (min. \$100/ max. \$200)		No out of network coverage.

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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
<u>coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a>	Specialty drugs	Subject to applicable copay		Specialty drugs may require precertification. Specialty drugs may be subject to dispensing limits.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
	Physician/surgeon fees	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
<b>If you need immediate medical attention</b>	Emergency room services	Deductible then 20% coinsurance	Deductible then 20% coinsurance	
	Emergency medical transportation	Deductible then 20% coinsurance	Deductible then 20% coinsurance	Includes emergency air transportation. Paid at in-network level if true emergency.
	Urgent care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Precertification required.
	Physician/surgeon fee	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$40 copayment/visit	Deductible then 40% coinsurance	
	Mental/Behavioral health inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Precertification required.
	Substance use disorder outpatient services	\$40 copayment/visit	Deductible then 40% coinsurance	
	Substance use disorder inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Precertification required.
<b>If you are pregnant</b>	Prenatal and postnatal care	Deductible then Covered 100%	Deductible then 40% coinsurance	

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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
	Delivery and all inpatient services	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Precertification required for extended stay.
<b>If you need help recovering or have other special health needs</b>	Home health care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 120 visits per year.
	Rehabilitation services	\$80 copayment/visit	Deductible then 40% coinsurance	Cardiac rehabilitation: Unlimited PT/OT/ST: Limited to 60 combined visits per year.
	Allergy Testing	Deductible then 20% coinsurance	Deductible then 40% coinsurance	
	Skilled nursing care	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Limited to 120 days per year.
	Durable medical equipment	Deductible then 20% coinsurance	Deductible then 40% coinsurance	Durable medical equipment includes medical supplies.
	Hospice service	Deductible then 20% coinsurance	Deductible then 40% coinsurance	

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## 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.)

- |   |                       |                        |
|---|-----------------------|------------------------|
| • Long-term Care                                      | • Cosmetic Surgery    | • Routine Foot Care    |
| • Non-Emergency Care while Traveling outside the U.S. | • Dental Care (Adult) | • Weight Loss Programs |

## 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 **800-422-7617**. 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](http://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](http://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: **800-422-7617** or visit us at [www.ibatpa.com](http://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](http://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](http://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.*—————

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## 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** \$3,020
- **Patient pays** \$4,520

#### 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
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$400
Copays	\$20
Coinsurance	\$900
Limits or exclusions	\$3,200
<b>Total</b>	<b>\$4,520</b>

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](http://www.ibatpa.com).

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** \$5,400
- **Plan pays** \$3,900
- **Patient pays** \$1,500

#### 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
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$400
Copays	\$600
Coinsurance	\$300
Limits or exclusions	\$200
<b>Total</b>	<b>\$1,500</b>

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](http://www.ibatpa.com).

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**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.

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