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, please contact the Plan Administrator at 1-800-572-2525. 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.hammer9fringe.com or call 1-800-572-2525 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Enhanced Plan - $250** person / **$500** family **Standard Plan - $500** person / **$1,000** family Does not apply to preventive care. Out of network co-insurance and copayments do not count toward the deductible.	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 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 services covered before you meet your deductible?	Yes. In-network **preventive care**, office visits and prescription drugs 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?	There are no other specific **deductibles**.	You don't have to meet specific **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For in-network providers is **$7,350** person / **$14,700** family.	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. There is a separate **coinsurance limit** of **$3,000**/person and **$6,000**/family for the **Enhanced Plan** and **$6,000**/person and **$12,000**/ family for the **Standard Plan** that accumulates toward the **out-of-pocket limit**.
What is not included in the out-of-pocket limit?	Premiums, self-payments, balance billed charges, dental, vision and health care this plan does not cover.	Even though you may be required to 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.MyIBXTPAbenefits.com or call 1-833-242-3330** for a list of participating 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 chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

⚠ 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
		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 copay/visit – **Enhanced Plan** $35 copay/visit – **Standard Plan**	40% coinsurance after deductible	---none---
	Specialist visit	$25 copay/visit – **Enhanced Plan** $35 copay/visit – **Standard Plan**	40% coinsurance after deductible	---none---
	Preventive care/screening/ immunization	No charge	40% coinsurance after deductible	Benefits covered at 100% in-network. Limitations may apply on number of visits.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Imaging (CT/PET scans, MRIs)	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hammer9fringe.com	Generic drugs	$10 copay / retail. $25 copay / mail order. – **Enhanced Plan** $15 copay / retail. $30 copay / mail order – **Standard Plan**	N/A	Covers up to a 34-day supply (retail prescription); Up to 90-day supply (mail order). 90-day supply for maintenance medications available at Walgreens retail pharmacies.
	Preferred brand drugs	25% with a $20 minimum copay / retail. $85 copay / mail order. **Enhanced Plan** 25% with a $40 minimum copay / retail. $170 copay / mail order **Standard Plan**	N/A	
	Non-preferred brand drugs	35% with a $30 minimum copay / retail. $100 copay / mail order. **Enhanced Plan** 35% with a $60 minimum copay / retail. $300 copay / mail order. **Standard Plan**	N/A	
	Weight Loss Drugs	30%	N/A	
	Specialty drugs	Refer to Generic, Preferred brand or Non-Preferred brand copays.	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Physician/surgeon fees	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need immediate medical attention	Emergency room care	$100 copay/visit – **Enhanced Plan** $200 copay/visit – **Standard Plan**	$100 copay/visit – **Enhanced Plan** $200 copay/visit – **Standard Plan**	Copay is waived for in-patient admissions or accidents

[* For more information about limitations and exceptions, see the plan or policy document at www.hammer9fringe.com.]

	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	---none---
	Urgent care	$25 copay/visit – **Enhanced Plan** $35 copay/visit – **Standard Plan**	40% coinsurance after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Physician/surgeon fees	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance after deductible	40% coinsurance after deductible	Limitations on number of visits may apply.
	Inpatient services	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If you are pregnant	Office visits	25% coinsurance after deductible	40% coinsurance after deductible	Preventive prenatal and postnatal care provided in-network at no charge. Limitations may apply on number of visits.
	Childbirth/delivery professional services	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Childbirth/delivery facility services	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If you need help recovering or have other special health needs	Home health care	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Rehabilitation services	25% coinsurance after deductible	40% coinsurance after deductible	Limitations on number of visits may apply.
	Habilitation services	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Skilled nursing care	25% coinsurance after deductible	40% coinsurance after deductible	Covered up to 120 days maximum per calendar year.
	Durable medical equipment	25% coinsurance after deductible	40% coinsurance after deductible	---none---
	Hospice services	25% coinsurance after deductible	40% coinsurance after deductible	---none---
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Vision benefits provided through VSP. Please contact the Plan Administrator at (800) 572-2525 for more details.
	Children's glasses	Not Covered	Not Covered	Vision benefits provided through VSP. Please contact the Plan Administrator at (800) 572-2525 for more details.
	Children's dental check-up	Not Covered	Not Covered	Dental benefits provided through Delta Dental and Dencap (formerly Golden Dental). Please contact the Plan Administrator at (800) 572-2525 for more details.

[* For more information about limitations and exceptions, see the plan or policy document at www.hammer9fringe.com.]

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 • Cosmetic surgery	• Long-term care • Private-duty nursing	• Weight Loss Programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care • Routine eye care - Adult (Vision benefits provided through VSP. Please contact the Plan Administrator at (800) 572-2525 for more details)	• Hearing aids • Infertility treatment • Non-emergency care when traveling outside the U.S.	• Routine foot care • Dental care (Dental benefits provided through Delta Dental and Dencap (formerly Golden Dental). Please contact the Plan Administrator at (800) 572-2525 for more details)

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: the Centers for Medicare & Medicaid Services – Office of COBRA Continuation Coverage at 1-866-444-3272. 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 Administrator at 1-800-572-2525.

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** **$250**
- **Specialist [cost sharing]** **$25**
- **Hospital (facility) [cost sharing]** **25%**
- **Other [cost sharing]** **25%**

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	**$7,540**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,756
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$2,006**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$250**
- **Specialist [cost sharing]** **$25**
- **Hospital (facility) [cost sharing]** **25%**
- **Other [cost sharing]** **25%**

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	$250
Copayments	$110
Coinsurance	$425
What isn't covered	
Limits or exclusions	$300
The total Joe would pay is	**$1,085**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$250**
- **Specialist [cost sharing]** **$25**
- **Hospital (facility) [cost sharing]** **25%**
- **Other [cost sharing]** **25%**

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	**$1,350**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$250
Copayments	$50
Coinsurance	$300
What isn't covered	
Limits or exclusions	$25
The total Mia would pay is	**$625**

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