

# 20 | Health plans

## 20 | for individuals and families



Independence 



**Choosing a health insurance plan is an important decision.  
We're glad you're considering Independence Blue Cross.**

We offer you the widest choice for quality care in the region, options that save you money, and personalized digital tools to help improve your health.

And when you need help, we're here to support you — online, over the phone, and even in person. We make it easy so you can stop worrying about health care and Live Fearless.

Take some time to review the information in this book. If you have questions or want help choosing or would like help with choosing or enrolling in a health plan, please contact your broker.





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# Why do you need HEALTH INSURANCE?



Health insurance is one of the most important purchases you can make for you and your family. Here are two good reasons why:

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## 1. It saves you money.

You'll pay less for health care when you need it, whether it's your annual physical, emergency care, or prescription medications. Plus, if you have an accident or suddenly get sick, you have coverage and can avoid owing large amounts for medical bills.

## 2. It helps you stay healthy.

Check-ups, preventive screenings, tests, and vaccines can help prevent more serious medical conditions down the road.



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## Why choose Independence?

Independence Blue Cross (Independence) is bringing you smarter, better health care.



The largest network  
of doctors and hospitals  
in the region



Flexible health plan  
options that meet your  
budget and needs



Telemedicine benefit  
so you can talk to  
a doctor 24/7 from  
anywhere in the U.S.



Top-rated mobile app full  
of tools to help you make  
informed decisions and  
improve your health



# How can you buy individual and family plans?

There are two ways to purchase an individual or family health plan. Use the information below to figure out which option is best for you and contact your broker if you have any questions.

## Directly through Independence

If you don't qualify for financial assistance, you'll want to choose from a variety of private health insurance plans offered directly from Independence. Plus, when you purchase directly from us, there are more cost-saving options and it's easier to make updates to your policy. Talk to your broker to find a plan that best meets your needs.

## Health Insurance Marketplace

The Marketplace at HealthCare.gov is operated by the federal government for the Commonwealth of Pennsylvania.

When you enroll in a health plan through HealthCare.gov, financial assistance may be available if you qualify. Sometimes called a tax credit or subsidy, financial assistance is available for those who qualify to help pay for health insurance costs. You may qualify for:

- Lower monthly premiums<sup>1</sup>
- Lower monthly premiums and lower out-of-pocket costs when you receive care<sup>2</sup>

### See if you may qualify

Your household income, where you live, and household size determine if you are eligible for a tax credit. Use the chart below to see if you may qualify. If you think you may qualify, use our online tax credit calculator at [ibx.com/calculator](https://ibx.com/calculator).

| Who needs coverage?        | What is the income for those covered under health plan?<br>(income % of Federal Poverty Level) |                           |                            |                             |
|----------------------------|------------------------------------------------------------------------------------------------|---------------------------|----------------------------|-----------------------------|
|                            | 138–149%                                                                                       | 150–199%                  | 200–249%                   | 250–400%                    |
| Single                     | \$17,236.20 – \$18,734.99                                                                      | \$18,735.00 – \$24,979.99 | \$24,980.00 – \$31,224.99  | \$31,225.00 – \$49,959.99   |
| Family of 2                | \$23,335.80 – \$25,364.99                                                                      | \$25,365.00 – \$33,819.99 | \$33,820.00 – \$42,274.99  | \$42,275.00 – \$67,639.99   |
| Family of 3                | \$29,435.40 – \$31,994.99                                                                      | \$31,995.00 – \$42,659.99 | \$42,660.00 – \$53,324.99  | \$53,325.00 – \$85,319.99   |
| Family of 4                | \$35,535.00 – \$38,624.99                                                                      | \$38,625.00 – \$51,499.99 | \$51,500.00 – \$64,374.99  | \$64,375.00 – \$102,999.99  |
| Family of 5                | \$41,634.60 – \$45,254.99                                                                      | \$45,255.00 – \$60,339.99 | \$60,340.00 – \$75,424.99  | \$75,425.00 – \$120,679.99  |
| Family of 6                | \$47,734.20 – \$51,884.99                                                                      | \$51,885.00 – \$69,179.99 | \$69,180.00 – \$86,474.99  | \$86,475.00 – \$138,359.99  |
| Family of 7                | \$53,833.80 – \$58,514.99                                                                      | \$58,515.00 – \$78,019.99 | \$78,020.00 – \$97,524.99  | \$97,525.00 – \$156,039.99  |
| Family of 8 <sup>3</sup>   | \$59,933.40 – \$65,144.99                                                                      | \$65,145.00 – \$86,859.99 | \$86,860.00 – \$108,574.99 | \$108,575.00 – \$173,719.99 |
| You may be eligible for... |                                                                                                |                           |                            |                             |
| Type                       | Premium tax credit and cost-sharing reduction (CSR)                                            |                           |                            | Premium tax credit          |
| Health plans               | Silver 138–149% CSR plans                                                                      | Silver 150–199% CSR plans | Silver 200–249% CSR plans  | Standard plans              |
| More info                  | p. 36–39                                                                                       | p. 32–35                  | p. 28–31                   | p. 15–25                    |

This chart is intended to give you an idea of whether you're eligible for a tax credit. Final eligibility determinations and the actual amount of your financial assistance will be determined by the federal government. Source: ASPE HHS, <https://aspe.hhs.gov/poverty-guidelines>.

1 If you qualify for a monthly premium tax credit, you can choose from any of the Standard plans at the Platinum, Gold, Silver, or Bronze levels. Even if you do not qualify for a tax credit, you can choose any one of these plans.

2 If you qualify for this type of assistance, you must select a Silver Cost-Share Reduction plan, which offers lower deductibles, copays, and coinsurance. If you do not select a Silver Cost-Share Reduction plan, you may still be able to get help paying your monthly premium, but you will not be able to get help in paying your deductibles, copays, and coinsurance.

3 For more than eight, add this amount for each additional person: \$4,420.

## Meet our health plans

All Independence individual and family health plans offer the same essential health benefits, which include doctor visits, hospital stays, prescription drug coverage, blood tests, X-rays, preventive care, and more. No matter what health plan you choose, you always have access to the full Independence Blue Cross network.

Under the Affordable Care Act, we are required to organize all plans by the level of coverage they offer using metallic tiers — Platinum, Gold, Silver, and Bronze. Since all plans cover the same essential health benefits, the difference is what you pay in monthly premium and out-of-pocket costs when you need care. We also offer a catastrophic plan for people younger than 30 or for those who qualify for a special exemption.

|                            |  <b>Platinum</b> |  <b>Gold</b> |  <b>Silver</b> |  <b>Bronze</b> |
|----------------------------|---------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Monthly cost               | \$\$\$\$                                                                                          | \$\$\$                                                                                        | \$\$                                                                                            | \$                                                                                                |
| Cost of care               | \$                                                                                                | \$\$                                                                                          | \$\$\$                                                                                          | \$\$\$\$                                                                                          |
| Good option if members ... | Plan to use a lot of health care services                                                         | Want to save on monthly premiums while keeping out-of-pocket costs low                        | Need to balance monthly premiums with out-of-pocket costs                                       | Don't plan to use a lot of health care services                                                   |

We offer three types of health plans:

- HMO (Health Maintenance Organization)
- EPO (Exclusive Provider Organization)
- PPO (Preferred Provider Organization)

Here are the main features of these health plans

|                                                | <div> <div>LOWER PREMIUM</div> <div>←.....→</div> <div>MORE FLEXIBILITY</div> </div>            |     |     |           |     |
|------------------------------------------------|-------------------------------------------------------------------------------------------------|-----|-----|-----------|-----|
|                                                | HMO Proactive                                                                                   | HMO | EPO | EPO + HSA | PPO |
| In-network coverage                            | ✓                                                                                               | ✓   | ✓   | ✓         | ✓   |
| Out-of-network coverage                        | For these health plans, out-of-network coverage is only available for urgent and emergent care. |     |     |           | ✓   |
| National access with the BlueCard® network     |                                                                                                 |     | ✓   | ✓         | ✓   |
| Required to select a primary care physician    | ✓                                                                                               | ✓   |     |           |     |
| Referrals needed for most specialists          | ✓                                                                                               | ✓   |     |           |     |
| Uses a tiered network to help you save on care | ✓                                                                                               |     |     |           |     |
| Option to open a tax-advantaged HSA            |                                                                                                 |     |     | ✓         |     |

Let's take a closer look at some of these terms. If you have questions about any other terms used throughout this book, please refer to the Glossary on p. 49.



### National BlueCard® network

With an EPO or PPO plan, you have in-network coverage for the national BlueCard network. That means you can visit any doctor or hospital in the Blue Cross Blue Shield PPO network anywhere in the United States, with 9 out of 10 doctors accepting your Independence ID card.

**96%** OF  
HOSPITALS



**95%** OF  
DOCTORS



### Primary care physician (PCP)

A PCP is your family doctor who treats your general health needs and can coordinate care by providing referrals to specialists, as needed. If you select an HMO plan, you are required to tell us who your PCP is.



### Tax-advantaged HSA

When you enroll in one of our EPO Reserve health plans, you can open a health savings account, or HSA. You pay no taxes on money you put into your HSA, and you can use those funds to pay for certain health care expenses (including dental and vision care costs). You can also earn tax-free interest or investment income on these funds. Any contributions you make are yours to keep, even if you change health plans later.

## WATCH YOUR SAVINGS GROW OVER TIME

An HSA can be a powerful savings tool. Let's say each year you contribute \$2,000 to your HSA and spend \$1,000 on qualified health expenses. With an investment return of 2 percent, your savings will grow each year.\*

### At the end of year 10

Tax Savings: \$3,810.37

HSA Balance: \$10,949.72

Account balances roll over from year-to-year, so unused funds are always yours — even when you retire.

The above information is for illustrative purposes only. The example assumes a 15 percent tax bracket, 3 percent state taxes, and that the investment choices yield a return of 2 percent. Please consult with your tax advisor for your situation. Return on investment is not guaranteed.

\* A \$2.50 investment account fee is assessed monthly by the vendor to account holders with an optional, self-directed investment account. Investment fees are omitted from the above example.

# Prescription drug benefits

All our medical plans include prescription drug coverage, so you get safe, affordable access to covered medications. Our prescription drug benefits are run by FutureScripts®, a national pharmacy benefits manager.

## Savings and convenience with Value Formulary

We're helping members lower out-of-pockets costs by covering generic and lower-cost brand alternatives. In addition, we also give prescribing doctors online access through their systems to see the most affordable medication options for your prescription drug plan — while they are deciding what to prescribe.

There are generally four levels of cost-sharing for prescription drugs, with generic drugs being the most affordable. In fact, in some plans members pay no more than \$4 for certain generics at participating retail pharmacies.



## Manage your medications



### Easy-to-use online tools

Log in at [ibx.com](https://ibx.com) to find a network pharmacy, estimate drug costs, review claims, and submit mail order requests.



### Mail order convenience

Sign up for free home delivery for medications you take regularly. In most plans, you can receive a 90-day supply for the cost of a 60-day supply at retail.



### Specialty drug savings

Get convenient delivery options and support from experienced pharmacists and nurses by phone or video chat with our specialty pharmacy program.

## In-network pharmacy options

The pharmacies included in your network are based on the medical plan you choose. Our broader pharmacy network includes 68,000 pharmacies nationwide.

Some of our plans use the Preferred Pharmacy network, which includes more than 59,000 pharmacies, including Walgreens. If you have the Preferred Pharmacy network and fill a prescription at an out-of-network pharmacy, such as Rite Aid, you will need to pay the up-front total cost at the pharmacy. You can then submit a claim, and you may be reimbursed for part of the cost.

Refer to p. 8–9 under “Special provisions” to see what pharmacy network each plan includes.

### NEW FOR 2020!

Preferred Pharmacy network now includes Walgreens. You can also get a 90-day supply of maintenance medication at any Walgreens for the same cost as mail order.



# Save with Keystone HMO Proactive, OUR MOST POPULAR PLANS

Our Keystone HMO Proactive health plans are our most popular for good reason: You get access to high-quality care and save money. Not only do you pay less for your monthly premiums, but you can save even more by choosing doctors and hospitals in Tier 1 – Preferred.

## Save with a tiered network plan

With a Keystone HMO Proactive health plan, in-network providers are grouped into three tiers. While all doctors and hospitals in our network must meet high quality standards, many offer services at a lower cost. These providers are in Tier 1 – Preferred, which includes more than 50 percent of in-network doctors and hospitals.

Tier 1 – Preferred



Tier 2 – Enhanced



Tier 3 – Standard



## Here are the most important things to remember about Keystone HMO Proactive:

- Like a typical HMO, you will select a PCP to coordinate your care and refer you to specialists.
- You can visit any doctor or hospital in the Independence Blue Cross network once you have a referral.
- There are some services that will cost the same no matter what provider you choose — like preventive care, emergency room visits, and urgent care.
- When you use doctors and hospitals in Tier 1 – Preferred, you pay the lowest out-of-pocket costs.
- The choice is always yours. You can choose Tier 1 – Preferred for some covered services and Tiers 2 or 3 for others.

## SAVE EVEN MORE WITH SELECT, VALUE, AND LITE OPTIONS



Keystone HMO Silver Proactive Select and Keystone HMO Silver Proactive Value plans are two lower-premium options that are only available when you purchase directly from Independence. Keystone HMO Silver Proactive Value includes a deductible for Tiers 1 – 3 for some services, whereas HMO Silver Proactive Select has no deductible for any services with Tier 1 providers.

New for 2020, Keystone HMO Silver Proactive Lite offers a lower premium for those shopping with a tax credit on HealthCare.gov. It includes a deductible for Tiers 1 – 3 for some services.

Be sure to review the details for these plans on p. 21–23 to make the right choice for you.

# Choose the health plan that fits your needs

We offer you a range of individual and family health plans in each coverage level so you can find one that fits your lifestyle and budget. All health plans include pediatric dental and vision coverage for individuals younger than 19.

| High-level plan comparison                    |                               |                        |                           |                        |                                                                                                         |                                     |                             |                                                                                                                                               |                     |
|-----------------------------------------------|-------------------------------|------------------------|---------------------------|------------------------|---------------------------------------------------------------------------------------------------------|-------------------------------------|-----------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|---------------------|
|                                               | Platinum                      |                        | Gold                      |                        |                                                                                                         | Silver                              |                             |                                                                                                                                               |                     |
| Plan Name                                     | Personal Choice® EPO Platinum | Keystone HMO Platinum  | Personal Choice® PPO Gold | Keystone HMO Gold      | Keystone HMO Gold Proactive                                                                             | Personal Choice® EPO Silver Reserve | Personal Choice® PPO Silver | Keystone HMO Silver Proactive                                                                                                                 | Keystone HMO Silver |
| Out-of-network benefits                       |                               |                        | ✓                         |                        |                                                                                                         |                                     | ✓                           |                                                                                                                                               |                     |
| Primary care physician and referrals required |                               | ✓                      |                           | ✓                      | ✓                                                                                                       |                                     |                             | ✓                                                                                                                                             | ✓                   |
| Out-of-pocket maximum                         | \$5,000                       | \$5,000                | \$7,000                   | \$7,000                | \$8,150                                                                                                 | \$6,900                             | \$7,500                     | \$8,150                                                                                                                                       | \$7,500             |
| Deductible                                    | \$0                           | \$0                    | \$0                       | \$0                    | \$0                                                                                                     | \$2,800                             | \$2,750                     | Tier 1 – \$0<br>Tier 2 – \$6,000<br>Tier 3 – \$6,000                                                                                          | \$2,750             |
| Primary care physician visit                  | \$15                          | \$20                   | \$30                      | \$35                   | Tier 1 – \$15<br>Tier 2 – \$30<br>Tier 3 – \$45                                                         | \$30 after ded                      | \$30 no ded                 | Tier 1 – \$40<br>Tier 2 – \$60 no ded<br>Tier 3 – \$70 no ded                                                                                 | \$35 no ded         |
| Specialist visit                              | \$50                          | \$50                   | \$65                      | \$65                   | Tier 1 – \$40<br>Tier 2 – \$60<br>Tier 3 – \$80                                                         | \$70 after ded                      | \$70 no ded                 | Tier 1 – \$80<br>Tier 2 – \$120 no ded<br>Tier 3 – \$140 no ded                                                                               | \$70 no ded         |
| Inpatient hospital                            | \$300/day <sup>1</sup>        | \$400/day <sup>1</sup> | \$750/day <sup>1</sup>    | \$750/day <sup>1</sup> | Tier 1 – \$350/day <sup>1</sup><br>Tier 2 – \$700/day <sup>1</sup><br>Tier 3 – \$1,100/day <sup>1</sup> | 25% after ded <sup>2</sup>          | 25% after ded <sup>2</sup>  | Tier 1 – \$600/day <sup>1</sup><br>Tier 2 – Subject to ded and \$900/day <sup>1</sup><br>Tier 3 – Subject to ded and \$1,300/day <sup>1</sup> | 30% after ded       |
| Generic prescription drugs                    | \$10                          | \$10                   | \$15                      | \$15                   | \$20                                                                                                    | 30% after ded                       | \$15 no ded                 | \$20 no ded (\$250 Rx ded for all prescription drugs except generic)                                                                          | \$15 no ded         |
| Special provisions                            | FP                            | FP                     | FP LCG                    | FP LCG                 | LCG MG<br>PP                                                                                            | HSA MG<br>PP                        | LCG MG<br>PP                | LCG MG<br>PP                                                                                                                                  | LCG MG<br>OFF PP    |

## Worksheet. Use this section to calculate your estimated premium

|                                                                      |    |    |    |    |    |    |    |    |    |
|----------------------------------------------------------------------|----|----|----|----|----|----|----|----|----|
| Fill in your monthly premium                                         | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| Fill in your tax credit (subsidy) amount                             | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |
| Subtract tax credit amount from monthly premium to see final premium |    |    |    |    |    |    |    |    |    |
| <b>Final premium</b>                                                 | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ | \$ |

ded = Deductible

Reserve = HSA qualified

<sup>1</sup> Amount shown reflects copay per day. There is a maximum of five copays per admission.

<sup>2</sup> For this plan, inpatient maternity hospital services are subject to 30 percent coinsurance after deductible.

<sup>3</sup> For PPO Bronze, inpatient maternity hospital services are subject to 50 percent coinsurance after deductible.

-  Most popular
-  FutureScripts Pharmacy network includes more than 68,000 pharmacies.
-  This plan is compatible with a health savings account.
-  Low-cost generics available at an even lower cost than standard generics.

-  **Mandatory Generics** — If you get a brand-name drug when a generic is available, you pay the difference in cost plus the brand-name cost-sharing. Choosing generics saves you money.
-  These plans can only be purchased through Independence directly and are not available on HealthCare.gov.

-  This plan is only available for purchase through the Federal Health Insurance Marketplace at HealthCare.gov.
-  Preferred Pharmacy network means your coverage is available at more than 59,000 pharmacies.

| Bronze                                                                                                                                                           |                                                                                                                                               |                                                                                                                                                                  |                                              |                                            |                                                |                                              | Catastrophic                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------|------------------------------------------------|----------------------------------------------|------------------------------------------------|
| NEW!<br>Keystone HMO<br>Silver Proactive Lite                                                                                                                    | Keystone HMO<br>Silver Proactive Select                                                                                                       | Keystone HMO Silver<br>Proactive Value                                                                                                                           | Personal<br>Choice® PPO<br>Bronze            | Personal<br>Choice® EPO<br>Bronze Reserve  | Personal<br>Choice®<br>EPO Bronze<br>Basic     | Keystone<br>HMO Bronze                       | Personal<br>Choice® EPO<br>Catastrophic        |
|                                                                                                                                                                  |                                                                                                                                               |                                                                                                                                                                  | ✓                                            |                                            |                                                |                                              |                                                |
| ✓                                                                                                                                                                | ✓                                                                                                                                             | ✓                                                                                                                                                                |                                              |                                            |                                                | ✓                                            |                                                |
| \$8,150                                                                                                                                                          | \$8,100                                                                                                                                       | \$8,150                                                                                                                                                          | \$8,150                                      | \$6,900                                    | \$8,150                                        | \$8,150                                      | \$8,150                                        |
| Tier 1 – \$2,000<br>Tier 2 – \$6,500<br>Tier 3 – \$6,500                                                                                                         | Tier 1 – \$0<br>Tier 2 – \$6,000<br>Tier 3 – \$6,000                                                                                          | Tier 1 – \$1,500<br>Tier 2 – \$6,000<br>Tier 3 – \$6,000                                                                                                         | \$5,750                                      | \$6,900                                    | \$8,150                                        | \$7,400                                      | \$8,150                                        |
| Tier 1 – \$50 no ded<br>Tier 2 – \$60 no ded<br>Tier 3 – \$70 no ded                                                                                             | Tier 1 – \$40<br>Tier 2 – \$60 no ded<br>Tier 3 – \$70 no ded                                                                                 | Tier 1 – \$40 no ded<br>Tier 2 – \$60 no ded<br>Tier 3 – \$70 no ded                                                                                             | \$50 no ded                                  | 0% after ded                               | Visits 1–3: \$40<br>Visits 4+: 0%<br>after ded | \$50 no ded                                  | Visits 1–3: \$50<br>Visits 4+: 0%<br>after ded |
| Tier 1 – \$100 no ded<br>Tier 2 – \$120 no ded<br>Tier 3 – \$140 no ded                                                                                          | Tier 1 – \$80<br>Tier 2 – \$120 no ded<br>Tier 3 – \$140 no ded                                                                               | Tier 1 – \$80 no ded<br>Tier 2 – \$120 no ded<br>Tier 3 – \$140 no ded                                                                                           | 50% after ded                                | 0% after ded                               | 0% after ded                                   | \$100 no ded                                 | 0% after ded                                   |
| Tier 1 – Subject to ded and \$600/day <sup>1</sup><br>Tier 2 – Subject to ded and \$900/day <sup>1</sup><br>Tier 3 – Subject to ded and \$1,300/day <sup>1</sup> | Tier 1 – \$600/day <sup>1</sup><br>Tier 2 – Subject to ded and \$900/day <sup>1</sup><br>Tier 3 – Subject to ded and \$1,300/day <sup>1</sup> | Tier 1 – Subject to ded and \$600/day <sup>1</sup><br>Tier 2 – Subject to ded and \$900/day <sup>1</sup><br>Tier 3 – Subject to ded and \$1,300/day <sup>1</sup> | 25% after ded <sup>3</sup>                   | 0% after ded                               | 0% after ded                                   | Subject to ded and \$700/day <sup>1</sup>    | 0% after ded                                   |
| \$20 no ded (\$250 Rx ded for all prescription drugs except generic)                                                                                             | \$20 no ded (\$250 Rx ded for all prescription drugs except generic)                                                                          | \$20 no ded (\$250 Rx ded for all prescription drugs except generic)                                                                                             | \$15 after ded (integrated with medical ded) | 0% after ded (integrated with medical ded) | 0% after ded (integrated with medical ded)     | \$15 after ded (integrated with medical ded) | 0% after ded (integrated with medical ded)     |
| LCG ON<br>MG PP                                                                                                                                                  | LCG MG<br>OFF PP                                                                                                                              | LCG MG<br>OFF PP                                                                                                                                                 | LCG MG<br>PP                                 | HSA MG<br>PP                               | MG PP                                          | LCG MG<br>OFF PP                             | MG PP                                          |
| \$                                                                                                                                                               | \$                                                                                                                                            | \$                                                                                                                                                               | \$                                           | \$                                         | \$                                             | \$                                           | \$                                             |
| \$                                                                                                                                                               | \$                                                                                                                                            | \$                                                                                                                                                               | \$                                           | \$                                         | \$                                             | \$                                           | \$                                             |
| \$                                                                                                                                                               | \$                                                                                                                                            | \$                                                                                                                                                               | \$                                           | \$                                         | \$                                             | \$                                           | \$                                             |

The summaries in this brochure represent only a partial listing of benefits of the Keystone Health Plan East and Personal Choice® plans. These managed care plans may not cover all of your health care expenses. Read your contract carefully to determine what health care services are covered. For more information, please contact your broker.

Questions? Contact your broker for assistance.

# Maximize YOUR BENEFITS

## Get healthy and save time and money with digital tools

### Access valuable information

Whether you're at home or on-the-go, you have 24/7 access to your benefits information and member tools. Log in at [ibx.com](http://ibx.com) or through our top-rated free mobile app to:

- View and print your ID card
- Access plan information (claims, spending, and benefits)
- Find a doctor or hospital near you
- Estimate your costs for care



### Get care — anytime, anywhere

We offer convenient care options whenever you need it — for both your physical and emotional health.



#### Telemedicine

.....

Skip the waiting room for non-emergency conditions like earaches, fever, pink eye, or rash. With telemedicine from MDLIVE, you get 24/7/365 access to a board-certified doctor by phone or video chat. Within minutes, you'll have a virtual visit, diagnosis, and any needed prescriptions sent to your pharmacy.



#### Tele-behavioral health

.....

Have a virtual visit by phone or video chat with a licensed behavioral health care professional (for example, psychologists and psychiatrists). Virtual visits are convenient, flexible, and completely confidential.



#### On To Better Health

.....

Using your computer or smartphone, you can access self-help tools and resources shown to help people improve their mental health for conditions like anxiety, depression, and insomnia. After a short online assessment, you'll get a customized, interactive, guided program that uses proven therapy techniques.

## Stay fit, for less

Our members get access to the new GlobalFit Anywhere app, which makes staying fit convenient and more affordable. You can choose from a variety of pay-as-you-go discounted classes, gym day passes, or personal training sessions through the mobile app. And there are no class limits or cancellation fees.



#### CONNECT WITH US

.....

Sign up to receive health screening reminders, important plan notifications, and alerts about exclusive member discounts and savings by text or email.

..... [ibx.com/getwired](http://ibx.com/getwired)



## Make the most of your health care dollars

### Avoid the ER when it's not an emergency

As a member, you don't have to go far for convenient, high-quality, lower-cost care when it's not an emergency but your doctor isn't available.



#### Retail clinics

Retail clinics are usually located within local pharmacies and employ certified nurse practitioners who can treat minor, uncomplicated illnesses and injuries, such as fevers, colds, rashes, bumps, and scrapes. There is no need for an appointment.



#### Urgent care centers

When you have an illness or injury that needs immediate attention but isn't life-threatening, an urgent care center is a faster, lower-cost option than the ER. No appointment is needed, and their board-certified doctors can treat conditions like sprains, sinus infections, and small wounds that need stitches.

### Or, use telemedicine

Members enrolled in a Bronze plan pay \$0, and members enrolled in Silver, Gold, or Platinum plans pay \$20 for a visit.\*

### Choose the right provider and save<sup>†</sup>

Our health plans give you choices when getting certain services. You can save on out-of-pocket costs — in some cases, hundreds of dollars — by getting care with certain providers:



#### Biotech/specialty injectables and infusion

- Lower cost-sharing when a drug is administered in your home or doctor's office instead of an outpatient setting



#### Outpatient surgery

- Lower cost-sharing for services at in-network ambulatory surgery centers (ASCs)



#### Preventive colonoscopy

- \$0 preventive colonoscopy when performed by non-hospital-based Preventive Plus providers and GI professionals



#### Physical/occupational therapy & routine complex radiology

- Lower cost-sharing at office-based providers or freestanding sites instead of hospital-based sites



#### Outpatient labs

- For most plans, cost-sharing for covered lab services is \$0 at a freestanding in-network lab. HMO plans offer 100 percent coverage for in-network labs when using their PCP's designated lab site.



#### FIND PROVIDERS EASILY

..... [ibx.com/findadoctor](https://ibx.com/findadoctor)

\*HSA-qualified and Catastrophic plans are excluded

†Benefits vary by health plan. Refer to the health plan charts beginning on p. 15 to review benefits for each plan.

# Achieve with INDEPENDENCE



Chronic health conditions and unhealthy lifestyle choices are a big part of the rising cost of health care. Whether you are generally healthy or need a little more support, our Achieve Well-being and Achieve Better Health programs can help you reach your health goals.

## Achieve Well-being

Self-service tools and resources to help you stay healthy:

- Up to \$450 in reimbursements for gym memberships and programs to help you manage your weight and quit smoking
- Online resources that make it easy and fun to achieve your health goals
- Action plans built just for you, including ongoing activities and reminders
- Ability to sync with fitness apps and devices so you can track your progress, create personal challenges, and invite friends to join
- Member-exclusive discounts on health-related products and services and deals on entertainment and events
- Up to six nutritional counseling sessions per benefit year — you pay \$0

## Achieve Better Health

Extra health support when you need it:



24/7 access to a Registered Nurse Health Coach by phone or email



Resources and support for members with chronic conditions



Case managers to help members with more serious illnesses or conditions



Maternity program support for pregnant members



# Complete your coverage with adult dental or vision

Make sure you're covered for all your health needs and enroll in an adult dental or vision plan through Independence. These plans can be purchased any time of the year, with or without a medical plan. All medical plans include pediatric dental and vision coverage for members younger than 19.



## Adult dental

Expect more from your adult dental plan. Choose from two dental PPO plans offering comprehensive benefits that include:

- **A network that goes the distance.** You get access to the national Concordia Advantage network, with 68,000 unique dentists at more than 250,000 access points across the country.<sup>1</sup>
- **Fully covered preventive and diagnostic services.\*** Fully covered services include routine exams, cleanings, and X-rays — pay \$0 at the time of your visit.
- **Coverage for most basic and major services (e.g., fillings, root canals).** There's no waiting period for preventive care and certain basic services like fillings and extractions.
- **Flexibility to see any dentist you want, nationally.†** You have the option to see any dentist without a referral. You can maximize your savings by using a participating dentist.
- **Discounts above the national average.** Maximize your savings when you use an in-network dentist. Our dental plans have discounts above the national average. And you get discounts on non-covered services with some in-network providers.
- **Hassle-free service.** 97 percent of calls are resolved with one call.<sup>1</sup> 98 percent of claims are paid within 30 days.<sup>1</sup>



## Adult vision

Expect more from your adult vision plan. Choose from two vision plans offering benefits that include:

- **A network that goes the distance.** You get access to the national Davis Vision network, with 84,000 access points across the country, including Visionworks stores and other retailers.
- **Fully covered routine annual eye exam.\*‡** When you use an in-network provider, you pay \$0 at the time of your visit.
- **\$0 and low-cost options for frames and lenses.** Choose from more than 220 frames in the Davis Vision Exclusive Collection. Or use an allowance to choose frames or contact lenses from in-network retailers nationwide, including Visionworks.
- **Discounts on other services.** Take advantage of discounts on other services, such as name-brand hearing aid technology from Your Hearing Network and laser eye correction.

See p. 41–42 for more details about the adult dental and vision plans we offer.



## Next step: Apply!

Contact your broker for assistance or to learn more about adult dental and vision plans.

<sup>1</sup> United Concordia Dental Internal Research and Reports; July 2019.

\*With an in-network provider

†There's no need to get referrals to see specialists, and there are no claim forms to submit when you see an in-network dentist.

‡There is a 30-day waiting period for all new vision plan contracts.

Independence dental plans are administered by United Concordia Companies, Inc., an independent company.

Independence Blue Cross vision plans are administered by Davis Vision, an independent company.

An affiliate of Independence Blue Cross has a financial interest in Visionworks.

Your Hearing Network products and services are made available through your coverage with Davis Vision. Your Hearing Network is not affiliated with Independence Blue Cross and does not provide Blue Cross or Blue Shield products or services. Your Hearing Network and/or Davis Vision are responsible for these products and services.



# 2020 Standard Plans

Our standard health plans include a wide range of options so you can choose the one that's best for you. For most of these plans, you can enroll at [HealthCare.gov](https://HealthCare.gov) if you qualify for financial assistance. If a plan is available only through Independence, it is marked as "OFF."



| Platinum health plans                                                                          | Personal Choice® EPO Platinum <sup>2</sup> | Keystone HMO Platinum <sup>2</sup>     |
|------------------------------------------------------------------------------------------------|--------------------------------------------|----------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup>            | You pay in-network <sup>3</sup>        |
| Ded, individual/family                                                                         | \$0/\$0                                    | \$0/\$0                                |
| Coinsurance                                                                                    | 0% unless otherwise noted                  | 0% unless otherwise noted              |
| Out-of-pocket maximum, individual/family includes:                                             | \$5,000/\$10,000 copay and coinsurance     | \$5,000/\$10,000 copay and coinsurance |
| Preventive services <sup>5</sup>                                                               |                                            |                                        |
| Preventive care for adults and children                                                        | \$0                                        | \$0                                    |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | \$0                                        | \$0                                    |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750                                      | \$750                                  |
| Physician services                                                                             |                                            |                                        |
| Primary care office visit/retail clinic                                                        | \$15                                       | \$20                                   |
| Specialist office visit                                                                        | \$50                                       | \$50                                   |
| Telemedicine <sup>28</sup>                                                                     | \$20                                       | \$20                                   |
| Urgent care                                                                                    | \$100                                      | \$100                                  |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | \$50                                       | \$50                                   |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$50/\$80                                  | \$50/\$50                              |
| Hospital/other medical services                                                                |                                            |                                        |
| Inpatient hospital services (includes maternity)                                               | \$300 per day <sup>7</sup>                 | \$400 per day <sup>7</sup>             |
| Inpatient professional services (includes maternity)                                           | \$0                                        | \$0                                    |
| Emergency room (not waived if admitted)                                                        | \$250                                      | \$250                                  |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | \$40/\$70                                  | \$40/\$40                              |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | \$80/\$120                                 | \$80/\$80                              |
| Biotech/specialty injectables — Home, office/outpatient                                        | \$100/\$200                                | \$60/\$120                             |
| Infusion — Home, office/outpatient                                                             | \$50/\$100                                 | \$50/\$100                             |
| Durable medical equipment/prosthetics                                                          | 50%                                        | 50%                                    |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$50                                       | \$50                                   |
| Mental health, serious mental illness & substance abuse — inpatient                            | \$300 per day <sup>7</sup>                 | \$400 per day <sup>7</sup>             |
| Outpatient surgery                                                                             |                                            |                                        |
| Ambulatory surgical facility                                                                   | 10% up to \$50 max                         | 10% up to \$100 max                    |
| Hospital-based                                                                                 | 10% up to \$250 max                        | 10% up to \$300 max                    |
| Outpatient lab/pathology                                                                       |                                            |                                        |
| Freestanding                                                                                   | \$0                                        | \$0                                    |
| Hospital-based                                                                                 | 50%                                        | \$0                                    |
| Prescription drugs <sup>14,15,†</sup>                                                          |                                            |                                        |
| Rx ded (individual/family)                                                                     | None                                       | None                                   |
| Retail generic <sup>16</sup>                                                                   | \$10                                       | \$10                                   |
| Retail preferred brand <sup>16</sup>                                                           | \$50                                       | \$50                                   |
| Retail non-preferred drug <sup>16</sup>                                                        | \$100                                      | \$100                                  |
| Specialty                                                                                      | 50% up to \$1,000                          | 50% up to \$1,000                      |
| Additional benefits                                                                            |                                            |                                        |
| Vision <sup>20,21</sup>                                                                        |                                            |                                        |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0                                        | \$0                                    |
| Dental <sup>24,25</sup>                                                                        |                                            |                                        |
| Pediatric dental ded (per individual)                                                          | \$50                                       | \$50                                   |
| Pediatric exams and cleanings <sup>26</sup>                                                    | \$0 no ded                                 | \$0 no ded                             |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 50% after ded                              | 50% after ded                          |



| Gold health plans                                                                              | Personal Choice® PPO Gold <sup>2</sup> |                                       |
|------------------------------------------------------------------------------------------------|----------------------------------------|---------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network                     | You pay out-of-network <sup>4</sup>   |
| Ded, individual/family                                                                         | \$0/\$0                                | \$6,000/\$12,000                      |
| Coinsurance                                                                                    | 20% unless otherwise noted             | 50% unless otherwise noted            |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                               | \$7,000/\$14,000 copay and coinsurance | \$12,000/\$24,000 ded and coinsurance |
| Preventive services <sup>5</sup>                                                               |                                        |                                       |
| Preventive care for adults and children                                                        | \$0                                    | 50% no ded                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | \$0                                    | n/a                                   |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750                                  | 50% no ded                            |
| Physician services                                                                             |                                        |                                       |
| Primary care office visit/retail clinic                                                        | \$30                                   | 50% after ded                         |
| Specialist office visit                                                                        | \$65                                   | 50% after ded                         |
| Telemedicine <sup>28</sup>                                                                     | \$20                                   | Not covered                           |
| Urgent care                                                                                    | \$100                                  | 50% after ded                         |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | \$50                                   | 50% after ded                         |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$65/\$95                              | 50% after ded/50% after ded           |
| Hospital/other medical services                                                                |                                        |                                       |
| Inpatient hospital services (includes maternity)                                               | \$750 per day <sup>7</sup>             | 50% after ded                         |
| Inpatient professional services (includes maternity)                                           | 20%                                    | 50% after ded                         |
| Emergency room (not waived if admitted)                                                        | \$350                                  | \$350 no ded                          |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | \$60/\$90                              | 50% after ded/50% after ded           |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | \$120/\$160                            | 50% after ded/50% after ded           |
| Biotech/specialty injectables — Home, office/outpatient                                        | \$120/\$240                            | 50% after ded/50% after ded           |
| Infusion — Home, office/outpatient                                                             | \$65/\$130                             | 50% after ded/50% after ded           |
| Durable medical equipment/prosthetics                                                          | 50%                                    | 50% after ded                         |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$65                                   | 50% after ded                         |
| Mental health, serious mental illness & substance abuse — inpatient                            | \$750 per day <sup>7</sup>             | 50% after ded                         |
| Outpatient surgery                                                                             |                                        |                                       |
| Ambulatory surgical facility                                                                   | 25% up to \$300 max                    | 50% after ded                         |
| Hospital-based                                                                                 | 25% up to \$700 max                    | 50% after ded                         |
| Outpatient lab/pathology                                                                       |                                        |                                       |
| Freestanding                                                                                   | \$0                                    | 50% after ded                         |
| Hospital-based                                                                                 | 50%                                    | 50% after ded                         |
| Prescription drugs <sup>14,15,†</sup>                                                          |                                        |                                       |
| Rx ded (individual/family)                                                                     | None                                   | None                                  |
| Retail generic                                                                                 | \$15 <sup>16,19</sup>                  | 70%                                   |
| Retail preferred brand                                                                         | 40% up to \$200 <sup>16</sup>          | 70%                                   |
| Retail non-preferred drug                                                                      | 50% up to \$200 <sup>16</sup>          | 70%                                   |
| Specialty                                                                                      | 50% up to \$1,000                      | Not covered                           |
| Additional benefits                                                                            |                                        |                                       |
| Vision <sup>20,21</sup>                                                                        |                                        |                                       |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0                                    | Not covered                           |
| Dental <sup>24,25</sup>                                                                        |                                        |                                       |
| Pediatric dental ded (per individual)                                                          | \$50                                   | n/a                                   |
| Pediatric exams and cleanings <sup>26</sup>                                                    | \$0 no ded                             | Not covered                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 50% after ded                          | Not covered                           |

| Keystone HMO Gold <sup>2</sup>         | Keystone HMO Gold Proactive <sup>2</sup>              |                                                      |                                                      |
|----------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| You pay in-network <sup>3</sup>        | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| \$0/\$0                                | \$0/\$0                                               | \$0/\$0                                              | \$0/\$0                                              |
| 20% unless otherwise noted             | 0% unless otherwise noted                             | 20% unless otherwise noted                           | 30% unless otherwise noted                           |
| \$7,000/\$14,000 copay and coinsurance | \$8,150/\$16,300 copay and coinsurance                | \$8,150/\$16,300 copay and coinsurance               | \$8,150/\$16,300 copay and coinsurance               |
|                                        |                                                       |                                                      |                                                      |
| \$0                                    | \$0                                                   | \$0                                                  | \$0                                                  |
| \$0                                    | \$0                                                   | \$0                                                  | \$0                                                  |
| \$750                                  | \$750                                                 | \$750                                                | \$750                                                |
|                                        |                                                       |                                                      |                                                      |
| \$35                                   | \$15 <sup>13</sup>                                    | \$30 <sup>13</sup>                                   | \$45 <sup>13</sup>                                   |
| \$65                                   | \$40                                                  | \$60                                                 | \$80                                                 |
| \$20                                   | \$20                                                  | \$20                                                 | \$20                                                 |
| \$100                                  | \$100                                                 | \$100                                                | \$100                                                |
| \$50                                   | \$50                                                  | \$50                                                 | \$50                                                 |
| \$65/\$65                              | \$60/\$60                                             | \$60/\$60                                            | \$60/\$60                                            |
|                                        |                                                       |                                                      |                                                      |
| \$750 per day <sup>7</sup>             | \$350 per day <sup>7</sup>                            | \$700 per day <sup>7</sup>                           | \$1,100 per day <sup>7</sup>                         |
| 20%                                    | 0%                                                    | 20%                                                  | 30%                                                  |
| \$350                                  | \$400 <sup>12</sup>                                   | \$400 <sup>12</sup>                                  | \$400 <sup>12</sup>                                  |
| \$60/\$60                              | \$60/\$60                                             | \$60/\$60                                            | \$60/\$60                                            |
| \$120/\$120                            | \$120/\$120                                           | \$120/\$120                                          | \$120/\$120                                          |
| \$120/\$240                            | 50%/50%                                               | 50%/50%                                              | 50%/50%                                              |
| \$65/\$130                             | 0%/0%                                                 | 20%/20%                                              | 30%/30%                                              |
| 50%                                    | 50%                                                   | 50%                                                  | 50%                                                  |
| \$65                                   | \$40                                                  | \$40                                                 | \$40                                                 |
| \$750 per day <sup>7</sup>             | \$350 per day <sup>7</sup>                            | \$350 per day <sup>7</sup>                           | \$350 per day <sup>7</sup>                           |
|                                        |                                                       |                                                      |                                                      |
| 25% up to \$300 max                    | \$150                                                 | \$550                                                | \$1,000                                              |
| 25% up to \$700 max                    | \$150                                                 | \$550                                                | \$1,000                                              |
|                                        |                                                       |                                                      |                                                      |
| \$0                                    | \$0                                                   | \$0                                                  | \$0                                                  |
| \$0                                    | \$0                                                   | \$0                                                  | \$0                                                  |
|                                        |                                                       |                                                      |                                                      |
| None                                   | None                                                  | None                                                 | None                                                 |
| \$15 <sup>16,19</sup>                  | \$20 <sup>16,17,19</sup>                              | \$20 <sup>16,17,19</sup>                             | \$20 <sup>16,17,19</sup>                             |
| 40% up to \$200 <sup>16</sup>          | 50% up to \$200 <sup>16,17,18</sup>                   | 50% up to \$200 <sup>16,17,18</sup>                  | 50% up to \$200 <sup>16,17,18</sup>                  |
| 50% up to \$200 <sup>16</sup>          | 50% up to \$300 <sup>16,17,18</sup>                   | 50% up to \$300 <sup>16,17,18</sup>                  | 50% up to \$300 <sup>16,17,18</sup>                  |
| 50% up to \$1,000                      | 50% up to \$1,000 <sup>17,18</sup>                    | 50% up to \$1,000 <sup>17,18</sup>                   | 50% up to \$1,000 <sup>17,18</sup>                   |
|                                        |                                                       |                                                      |                                                      |
|                                        |                                                       |                                                      |                                                      |
| \$0                                    | \$0                                                   | \$0                                                  | \$0                                                  |
|                                        |                                                       |                                                      |                                                      |
| \$50                                   | \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                             | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                          | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

| Silver health plans                                                                            | Personal Choice <sup>®</sup> EPO Silver Reserve <sup>2</sup> |
|------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup>                              |
| Ded, individual/family                                                                         | \$2,800/\$5,600                                              |
| Coinsurance                                                                                    | 30% unless otherwise noted                                   |
| Out-of-pocket maximum, individual/family includes:                                             | \$6,900/\$13,800 copay, ded, and coinsurance                 |
| Preventive services <sup>5</sup>                                                               |                                                              |
| Preventive care for adults and children                                                        | 0% no ded                                                    |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | 0% no ded                                                    |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750 no ded                                                 |
| Physician services                                                                             |                                                              |
| Primary care office visit/retail clinic                                                        | \$30 after ded                                               |
| Specialist office visit                                                                        | \$70 after ded                                               |
| Telemedicine <sup>28</sup>                                                                     | 30% after ded                                                |
| Urgent care                                                                                    | 30% after ded                                                |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | 30% after ded                                                |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$70 after ded /\$70 after ded                               |
| Hospital/other medical services                                                                |                                                              |
| Inpatient hospital services (includes maternity)                                               | 25% after ded <sup>8</sup>                                   |
| Inpatient professional services (includes maternity)                                           | 30% after ded                                                |
| Emergency room (not waived if admitted)                                                        | 30% after ded                                                |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | 30% after ded/30% after ded                                  |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | 30% after ded/30% after ded                                  |
| Biotech/specialty injectables — Home, office/outpatient                                        | 30% after ded/30% after ded                                  |
| Infusion — Home, office/outpatient                                                             | 30% after ded/30% after ded                                  |
| Durable medical equipment/prosthetics                                                          | 30% after ded                                                |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$70 after ded                                               |
| Mental health, serious mental illness & substance abuse — inpatient                            | 25% after ded                                                |
| Outpatient surgery                                                                             |                                                              |
| Ambulatory surgical facility                                                                   | 30% after ded                                                |
| Hospital-based                                                                                 | 30% after ded                                                |
| Outpatient lab/pathology                                                                       |                                                              |
| Freestanding                                                                                   | 30% after ded                                                |
| Hospital-based                                                                                 | 30% after ded                                                |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |                                                              |
| Rx ded (individual/family)                                                                     | Integrated with medical ded                                  |
| Retail generic                                                                                 | 30% after ded <sup>16</sup>                                  |
| Retail preferred brand <sup>18</sup>                                                           | 30% after ded <sup>16</sup>                                  |
| Retail non-preferred drug <sup>18</sup>                                                        | 30% after ded <sup>16</sup>                                  |
| Specialty <sup>18</sup>                                                                        | 50% after ded up to \$1,000                                  |
| Additional benefits                                                                            |                                                              |
| Vision <sup>20,21</sup>                                                                        |                                                              |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0 no ded                                                   |
| Dental <sup>24,25</sup>                                                                        |                                                              |
| Pediatric dental ded (per individual)                                                          | Integrated with medical ded                                  |
| Pediatric exams and cleanings <sup>26</sup>                                                    | 0% no ded                                                    |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 30% after ded                                                |

Personal Choice® PPO Silver<sup>2</sup>

| You pay in-network                           | You pay out-of-network <sup>4</sup>   |
|----------------------------------------------|---------------------------------------|
| \$2,750/\$5,500                              | \$10,000/\$20,000                     |
| 30% unless otherwise noted                   | 50% unless otherwise noted            |
| \$7,500/\$15,000 copay, ded, and coinsurance | \$20,000/\$40,000 ded and coinsurance |
| 0% no ded                                    | 50% no ded                            |
| 0% no ded                                    | n/a                                   |
| \$750 no ded                                 | 50% no ded                            |
| \$30 no ded                                  | 50% after ded                         |
| \$70 no ded                                  | 50% after ded                         |
| \$20 no ded                                  | Not covered                           |
| 30% after ded                                | 50% after ded                         |
| 30% after ded                                | 50% after ded                         |
| \$70 no ded/\$100 no ded                     | 50% after ded/50% after ded           |
| 25% after ded <sup>8</sup>                   | 50% after ded                         |
| 30% after ded                                | 50% after ded                         |
| 30% after ded                                | 30% after in-network ded              |
| 30% after ded /50% after ded                 | 50% after ded/50% after ded           |
| 30% after ded /50% after ded                 | 50% after ded/50% after ded           |
| 30% after ded/50% after ded                  | 50% after ded/50% after ded           |
| 30% after ded/50% after ded                  | 50% after ded/50% after ded           |
| 50% after ded                                | 50% after ded                         |
| \$70 no ded                                  | 50% after ded                         |
| 25% after ded                                | 50% after ded                         |
| 30% after ded                                | 50% after ded                         |
| 50% after ded                                | 50% after ded                         |
| 0% no ded                                    | 50% after ded                         |
| 50% no ded                                   | 50% after ded                         |
| Integrated with medical ded                  | Integrated with medical ded           |
| \$15 no ded <sup>16,19</sup>                 | 70% no ded                            |
| 50% after ded up to \$300 <sup>16</sup>      | 70% after ded                         |
| 50% after ded up to \$400 <sup>16</sup>      | 70% after ded                         |
| 50% after ded up to \$1,000                  | Not covered                           |
| \$0 no ded                                   | Not covered                           |
| \$50                                         | n/a                                   |
| \$0 no ded                                   | Not covered                           |
| 50% after ded                                | Not covered                           |



These plans are not offered on HealthCare.gov and must be purchased through Independence directly.

Footnotes begin on page 43 | ded = Deductible

Questions? Contact your broker for assistance.



| Silver health plans                                                                            | Keystone HMO Silver Proactive <sup>2</sup>            |                                                      |                                                      |
|------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| Ded, individual/family <sup>10</sup>                                                           | \$0/\$0                                               | \$6,000/\$12,000                                     | \$6,000/\$12,000                                     |
| Coinsurance                                                                                    | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                               | \$8,150/\$16,300<br>copay and coinsurance             | \$8,150/\$16,300<br>copay, ded, and coinsurance      | \$8,150/\$16,300<br>copay, ded, and coinsurance      |
| Preventive services <sup>5</sup>                                                               |                                                       |                                                      |                                                      |
| Preventive care for adults and children                                                        | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750                                                 | \$750 no ded                                         | \$750 no ded                                         |
| Physician services                                                                             |                                                       |                                                      |                                                      |
| Primary care office visit/retail clinic <sup>13</sup>                                          | \$40                                                  | \$60 no ded                                          | \$70 no ded                                          |
| Specialist office visit                                                                        | \$80                                                  | \$120 no ded                                         | \$140 no ded                                         |
| Telemedicine <sup>28</sup>                                                                     | \$20                                                  | \$20 no ded                                          | \$20 no ded                                          |
| Urgent care                                                                                    | \$100                                                 | \$100 no ded                                         | \$100 no ded                                         |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | \$50                                                  | \$50 no ded                                          | \$50 no ded                                          |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$80/\$80                                             | \$80 no ded/\$80 no ded                              | \$80 no ded/\$80 no ded                              |
| Hospital/other medical services                                                                |                                                       |                                                      |                                                      |
| Inpatient hospital services (includes maternity)                                               | \$600 per day <sup>7</sup>                            | Subject to ded and \$900 per day <sup>7</sup>        | Subject to ded and \$1,300 per day <sup>7</sup>      |
| Inpatient professional services (includes maternity)                                           | 0%                                                    | 5% after ded                                         | 10% after ded                                        |
| Emergency room (not waived if admitted) <sup>12</sup>                                          | \$550                                                 | \$550 no ded                                         | \$550 no ded                                         |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | \$120/\$120                                           | \$120 no ded/\$120 no ded                            | \$120 no ded/\$120 no ded                            |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | \$250/\$250                                           | \$250 no ded/\$250 no ded                            | \$250 no ded/\$250 no ded                            |
| Biotech/specialty injectables — Home, office/outpatient                                        | 50%/50%                                               | 50% no ded/50% no ded                                | 50% no ded/50% no ded                                |
| Infusion — Home, office/outpatient                                                             | 0%/0%                                                 | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| Durable medical equipment/prosthetics                                                          | 50%                                                   | 50% no ded                                           | 50% no ded                                           |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$80                                                  | \$80 no ded                                          | \$80 no ded                                          |
| Mental health, serious mental illness & substance abuse — inpatient                            | \$600 per day <sup>7</sup>                            | \$600 per day no ded <sup>7</sup>                    | \$600 per day no ded <sup>7</sup>                    |
| Outpatient surgery                                                                             |                                                       |                                                      |                                                      |
| Ambulatory surgical facility                                                                   | \$250                                                 | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Hospital-based                                                                                 | \$250                                                 | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Outpatient lab/pathology                                                                       |                                                       |                                                      |                                                      |
| Freestanding                                                                                   | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Hospital-based                                                                                 | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |                                                       |                                                      |                                                      |
| Rx ded (individual/family)                                                                     | \$250/\$500 <sup>‡</sup>                              | \$250/\$500 <sup>‡</sup>                             | \$250/\$500 <sup>‡</sup>                             |
| Retail generic <sup>16,19</sup>                                                                | \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| Retail preferred brand <sup>16,18</sup>                                                        | 50% after ded up to \$400                             | 50% after ded up to \$400                            | 50% after ded up to \$400                            |
| Retail non-preferred drug <sup>16,18</sup>                                                     | 50% after ded up to \$500                             | 50% after ded up to \$500                            | 50% after ded up to \$500                            |
| Specialty <sup>18</sup>                                                                        | 50% after ded up to \$1,000                           | 50% after ded up to \$1,000                          | 50% after ded up to \$1,000                          |
| Additional benefits                                                                            |                                                       |                                                      |                                                      |
| Vision <sup>20,21</sup>                                                                        |                                                       |                                                      |                                                      |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0                                                   | \$0 no ded                                           | \$0 no ded                                           |
| Dental <sup>24,25</sup>                                                                        |                                                       |                                                      |                                                      |
| Pediatric dental ded (per individual)                                                          | \$50                                                  | \$50                                                 | \$50                                                 |
| Pediatric exams and cleanings <sup>26</sup>                                                    | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

| OFF Keystone HMO Silver <sup>2</sup>         | ON Keystone HMO Silver Proactive Lite <sup>2</sup>    |                                                      |                                                      |
|----------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| You pay in-network <sup>3</sup>              | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| \$2,750/\$5,500                              | \$2,000/\$4,000                                       | \$6,500/\$13,000                                     | \$6,500/\$13,000                                     |
| 30% unless otherwise noted                   | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| \$7,500/\$15,000 copay, ded, and coinsurance | \$8,150/\$16,300 copay, ded, and coinsurance          | \$8,150/\$16,300 copay, ded, and coinsurance         | \$8,150/\$16,300 copay, ded, and coinsurance         |
| 0% no ded                                    | 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                    | 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$750 no ded                                 | \$750 no ded                                          | \$750 no ded                                         | \$750 no ded                                         |
| \$35 no ded                                  | \$50 no ded                                           | \$60 no ded                                          | \$70 no ded                                          |
| \$70 no ded                                  | \$100 no ded                                          | \$120 no ded                                         | \$140 no ded                                         |
| \$20 no ded                                  | \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| 30% after ded                                | \$100 no ded                                          | \$100 no ded                                         | \$100 no ded                                         |
| 30% after ded                                | \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$70 no ded/\$70 no ded                      | \$100 no ded/\$100 no ded                             | \$100 no ded/\$100 no ded                            | \$100 no ded/\$100 no ded                            |
| 30% after ded                                | Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$900 per day <sup>7</sup>        | Subject to ded and \$1,300 per day <sup>7</sup>      |
| 30% after ded                                | 0% after ded                                          | 5% after ded                                         | 10% after ded                                        |
| 30% after ded                                | \$600 no ded                                          | \$600 no ded                                         | \$600 no ded                                         |
| \$120 no ded/\$120 no ded                    | \$150 no ded/\$150 no ded                             | \$150 no ded/\$150 no ded                            | \$150 no ded/\$150 no ded                            |
| \$250 no ded/\$250 no ded                    | \$250 no ded/\$250 no ded                             | \$250 no ded/\$250 no ded                            | \$250 no ded/\$250 no ded                            |
| 30% after ded/50% after ded                  | 50% no ded/50% no ded                                 | 50% no ded/50% no ded                                | 50% no ded/50% no ded                                |
| 30% after ded/50% after ded                  | 0% after ded/0% after ded                             | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| 50% after ded                                | 50% no ded                                            | 50% no ded                                           | 50% no ded                                           |
| \$70 no ded                                  | \$100 no ded                                          | \$100 no ded                                         | \$100 no ded                                         |
| 30% after ded                                | Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$600 per day <sup>7</sup>        | Subject to ded and \$600 per day <sup>7</sup>        |
| 30% after ded                                | Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| 50% after ded                                | Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| 0% no ded                                    | 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                    | 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| Integrated with medical ded                  | \$250/\$500 <sup>†</sup>                              | \$250/\$500 <sup>†</sup>                             | \$250/\$500 <sup>†</sup>                             |
| \$15 no ded                                  | \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| 50% after ded up to \$300                    | 50% after ded up to \$400                             | 50% after ded up to \$400                            | 50% after ded up to \$400                            |
| 50% after ded up to \$400                    | 50% after ded up to \$500                             | 50% after ded up to \$500                            | 50% after ded up to \$500                            |
| 50% after ded up to \$1,000                  | 50% after ded up to \$1,000                           | 50% after ded up to \$1,000                          | 50% after ded up to \$1,000                          |
| \$0 no ded                                   | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| \$50                                         | \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                                   | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                                | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

OFF These plans are not offered on HealthCare.gov and must be purchased through Independence directly. Footnotes begin on page 43 | ded = Deductible

ON These plans must be purchased on HealthCare.gov and cannot be purchased through Independence directly.

Questions? Contact your broker for assistance.

## Silver health plans

## OFF Keystone HMO Silver Proactive Select<sup>2</sup>

### Benefits per calendar year<sup>1</sup>

|                                                                  | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
|------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| Ded, individual/family <sup>10</sup>                             | \$0/\$0                                               | \$6,000/\$12,000                                     | \$6,000/\$12,000                                     |
| Coinsurance                                                      | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup> | \$8,100/\$16,200<br>copay and coinsurance             | \$8,100/\$16,200<br>copay, ded, and coinsurance      | \$8,100/\$16,200<br>copay, ded, and coinsurance      |

### Preventive services<sup>5</sup>

|                                                                                    |       |              |              |
|------------------------------------------------------------------------------------|-------|--------------|--------------|
| Preventive care for adults and children                                            | 0%    | 0% no ded    | 0% no ded    |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | 0%    | 0% no ded    | 0% no ded    |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based            | \$750 | \$750 no ded | \$750 no ded |

### Physician services

|                                                                                                |           |                         |                         |
|------------------------------------------------------------------------------------------------|-----------|-------------------------|-------------------------|
| Primary care office visit/retail clinic <sup>13</sup>                                          | \$40      | \$60 no ded             | \$70 no ded             |
| Specialist office visit                                                                        | \$80      | \$120 no ded            | \$140 no ded            |
| Telemedicine <sup>28</sup>                                                                     | \$20      | \$20 no ded             | \$20 no ded             |
| Urgent care                                                                                    | \$100     | \$100 no ded            | \$100 no ded            |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | \$50      | \$50 no ded             | \$50 no ded             |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$80/\$80 | \$80 no ded/\$80 no ded | \$80 no ded/\$80 no ded |

### Hospital/other medical services

|                                                                      |                            |                                               |                                                 |
|----------------------------------------------------------------------|----------------------------|-----------------------------------------------|-------------------------------------------------|
| Inpatient hospital services (includes maternity)                     | \$600 per day <sup>7</sup> | Subject to ded and \$900 per day <sup>7</sup> | Subject to ded and \$1,300 per day <sup>7</sup> |
| Inpatient professional services (includes maternity)                 | 0%                         | 5% after ded                                  | 10% after ded                                   |
| Emergency room (not waived if admitted) <sup>12</sup>                | \$550                      | \$550 no ded                                  | \$550 no ded                                    |
| Routine radiology/diagnostic — Freestanding/Hospital-based           | \$120/\$120                | \$120 no ded/\$120 no ded                     | \$120 no ded/\$120 no ded                       |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based         | \$250/\$250                | \$250 no ded/\$250 no ded                     | \$250 no ded/\$250 no ded                       |
| Biotech/specialty injectables — Home, office/outpatient              | 50%/50%                    | 50% no ded/50% no ded                         | 50% no ded/50% no ded                           |
| Infusion — Home, office/outpatient                                   | 0%/0%                      | 5% after ded/5% after ded                     | 10% after ded/10% after ded                     |
| Durable medical equipment/prosthetics                                | 50%                        | 50% no ded                                    | 50% no ded                                      |
| Mental health, serious mental illness & substance abuse — outpatient | \$80                       | \$80 no ded                                   | \$80 no ded                                     |
| Mental health, serious mental illness & substance abuse — inpatient  | \$600 per day <sup>7</sup> | \$600 per day no ded <sup>7</sup>             | \$600 per day no ded <sup>7</sup>               |

### Outpatient surgery

|                              |       |                                |                                  |
|------------------------------|-------|--------------------------------|----------------------------------|
| Ambulatory surgical facility | \$250 | Subject to ded and \$750 copay | Subject to ded and \$1,250 copay |
| Hospital-based               | \$250 | Subject to ded and \$750 copay | Subject to ded and \$1,250 copay |

### Outpatient lab/pathology

|                |    |           |           |
|----------------|----|-----------|-----------|
| Freestanding   | 0% | 0% no ded | 0% no ded |
| Hospital-based | 0% | 0% no ded | 0% no ded |

### Prescription drugs<sup>14,15,17,1</sup>

|                                            |                             |                             |                             |
|--------------------------------------------|-----------------------------|-----------------------------|-----------------------------|
| Rx ded (individual/family) <sup>4</sup>    | \$250/\$500                 | \$250/\$500                 | \$250/\$500                 |
| Retail generic <sup>16,19</sup>            | \$20 no ded                 | \$20 no ded                 | \$20 no ded                 |
| Retail preferred brand <sup>16,18</sup>    | 50% after ded up to \$400   | 50% after ded up to \$400   | 50% after ded up to \$400   |
| Retail non-preferred drug <sup>16,18</sup> | 50% after ded up to \$500   | 50% after ded up to \$500   | 50% after ded up to \$500   |
| Specialty <sup>18</sup>                    | 50% after ded up to \$1,000 | 50% after ded up to \$1,000 | 50% after ded up to \$1,000 |

### Additional benefits

|                                                                |               |               |               |
|----------------------------------------------------------------|---------------|---------------|---------------|
| Vision <sup>20,21</sup>                                        |               |               |               |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>            | \$0           | \$0 no ded    | \$0 no ded    |
| Dental <sup>24,25</sup>                                        |               |               |               |
| Pediatric dental ded (per individual)                          | \$50          | \$50          | \$50          |
| Pediatric exams and cleanings <sup>26</sup>                    | \$0 no ded    | \$0 no ded    | \$0 no ded    |
| Pediatric basic, major, and orthodontia services <sup>27</sup> | 50% after ded | 50% after ded | 50% after ded |

 **Keystone HMO Silver Proactive Value<sup>2</sup>**

| You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| \$1,500/\$3,000                                       | \$6,000/\$12,000                                     | \$6,000/\$12,000                                     |
| 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| \$8,150/\$16,300<br>copay, ded, and coinsurance       | \$8,150/\$16,300<br>copay, ded, and coinsurance      | \$8,150/\$16,300<br>copay, ded, and coinsurance      |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$750 no ded                                          | \$750 no ded                                         | \$750 no ded                                         |
| \$40 no ded                                           | \$60 no ded                                          | \$70 no ded                                          |
| \$80 no ded                                           | \$120 no ded                                         | \$140 no ded                                         |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| \$100 no ded                                          | \$100 no ded                                         | \$100 no ded                                         |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$80 no ded/\$80 no ded                               | \$80 no ded/\$80 no ded                              | \$80 no ded/\$80 no ded                              |
| Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$900 per day <sup>7</sup>        | Subject to ded and \$1,300 per day <sup>7</sup>      |
| 0% after ded                                          | 5% after ded                                         | 10% after ded                                        |
| \$550 no ded                                          | \$550 no ded                                         | \$550 no ded                                         |
| \$120 no ded/\$120 no ded                             | \$120 no ded/\$120 no ded                            | \$120 no ded/\$120 no ded                            |
| \$250 no ded/\$250 no ded                             | \$250 no ded/\$250 no ded                            | \$250 no ded/\$250 no ded                            |
| 50% no ded/50% no ded                                 | 50% no ded/50% no ded                                | 50% no ded/50% no ded                                |
| 0% after ded/0% after ded                             | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| 50% no ded                                            | 50% no ded                                           | 50% no ded                                           |
| \$80 no ded                                           | \$80 no ded                                          | \$80 no ded                                          |
| Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$600 per day <sup>7</sup>        | Subject to ded and \$600 per day <sup>7</sup>        |
| Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$250/\$500                                           | \$250/\$500                                          | \$250/\$500                                          |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| 50% after ded up to \$400                             | 50% after ded up to \$400                            | 50% after ded up to \$400                            |
| 50% after ded up to \$500                             | 50% after ded up to \$500                            | 50% after ded up to \$500                            |
| 50% after ded up to \$1,000                           | 50% after ded up to \$1,000                          | 50% after ded up to \$1,000                          |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

 These plans are not offered on HealthCare.gov and must be purchased through Independence directly.

Footnotes begin on page 43 | ded = Deductible

Questions? Contact your broker for assistance.

| Bronze health plans                                                                            |  | Personal Choice® PPO Bronze <sup>2</sup>     |                                       |
|------------------------------------------------------------------------------------------------|--|----------------------------------------------|---------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        |  | You pay in-network                           | You pay out-of-network <sup>4</sup>   |
| Ded, individual/family                                                                         |  | \$5,750/\$11,500                             | \$15,000/\$30,000                     |
| Coinsurance                                                                                    |  | 50% unless otherwise noted                   | 50% unless otherwise noted            |
| Out-of-pocket maximum, individual/family includes:                                             |  | \$8,150/\$16,300 copay, ded, and coinsurance | \$25,000/\$50,000 ded and coinsurance |
| Preventive services <sup>5</sup>                                                               |  |                                              |                                       |
| Preventive care for adults and children                                                        |  | 0% no ded                                    | 50% no ded                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             |  | 0% no ded                                    | n/a                                   |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        |  | \$750 no ded                                 | 50% no ded                            |
| Physician services                                                                             |  |                                              |                                       |
| Primary care office visit/retail clinic                                                        |  | \$50 no ded                                  | 50% after ded                         |
| Specialist office visit                                                                        |  | 50% after ded                                | 50% after ded                         |
| Telemedicine <sup>28</sup>                                                                     |  | \$0 no ded                                   | Not covered                           |
| Urgent care                                                                                    |  | 50% after ded                                | 50% after ded                         |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         |  | 50% after ded                                | 50% after ded                         |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> |  | 50% after ded/50% after ded                  | 50% after ded/50% after ded           |
| Hospital/other medical services                                                                |  |                                              |                                       |
| Inpatient hospital services (includes maternity)                                               |  | 25% after ded <sup>9</sup>                   | 50% after ded                         |
| Inpatient professional services (includes maternity)                                           |  | 50% after ded                                | 50% after ded                         |
| Emergency room (not waived if admitted)                                                        |  | 50% after ded                                | 50% after in-network ded              |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     |  | 50% after ded/50% after ded                  | 50% after ded/50% after ded           |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   |  | 50% after ded/50% after ded                  | 50% after ded/50% after ded           |
| Biotech/specialty injectables — Home, office/outpatient                                        |  | 50% after ded/50% after ded                  | 50% after ded/50% after ded           |
| Infusion — Home, office/outpatient                                                             |  | 50% after ded/50% after ded                  | 50% after ded/50% after ded           |
| Durable medical equipment/prosthetics                                                          |  | 50% after ded                                | 50% after ded                         |
| Mental health, serious mental illness & substance abuse — outpatient                           |  | 50% after ded                                | 50% after ded                         |
| Mental health, serious mental illness & substance abuse — inpatient                            |  | 25% after ded                                | 50% after ded                         |
| Outpatient surgery                                                                             |  |                                              |                                       |
| Ambulatory surgical facility                                                                   |  | 50% after ded                                | 50% after ded                         |
| Hospital-based                                                                                 |  | 50% after ded                                | 50% after ded                         |
| Outpatient lab/pathology                                                                       |  |                                              |                                       |
| Freestanding                                                                                   |  | 0% after ded                                 | 50% after ded                         |
| Hospital-based                                                                                 |  | 50% after ded                                | 50% after ded                         |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |  |                                              |                                       |
| Rx ded (individual/family)                                                                     |  | Integrated with medical ded                  | Integrated with medical ded           |
| Retail generic                                                                                 |  | \$15 after ded <sup>16,19</sup>              | 70% after ded                         |
| Retail preferred brand <sup>18</sup>                                                           |  | 50% after ded <sup>16</sup>                  | 70% after ded                         |
| Retail non-preferred drug <sup>18</sup>                                                        |  | 50% after ded <sup>16</sup>                  | 70% after ded                         |
| Specialty <sup>18</sup>                                                                        |  | 50% after ded                                | Not covered                           |
| Additional benefits                                                                            |  |                                              |                                       |
| Vision <sup>20,21</sup>                                                                        |  |                                              |                                       |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            |  | \$0 no ded                                   | Not covered                           |
| Dental <sup>24,25</sup>                                                                        |  |                                              |                                       |
| Pediatric dental ded (per individual)                                                          |  | \$50                                         | n/a                                   |
| Pediatric exams and cleanings <sup>26</sup>                                                    |  | \$0 no ded                                   | Not covered                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 |  | 50% after ded                                | Not covered                           |



| Personal Choice® EPO Bronze Reserve <sup>2</sup> | Personal Choice® EPO Bronze Basic <sup>2</sup>                | OFF Keystone HMO Bronze <sup>2</sup>          |
|--------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------|
| You pay in-network <sup>3</sup>                  | You pay in-network <sup>3</sup>                               | You pay in-network <sup>3</sup>               |
| \$6,900/\$13,800                                 | \$8,150/\$16,300                                              | \$7,400/\$14,800                              |
| 0%                                               | 0%                                                            | 50% unless otherwise noted                    |
| \$6,900/\$13,800 copay, ded and coinsurance      | \$8,150/\$16,300 copay, ded and coinsurance                   | 8,150/16,300 copay, ded, and coinsurance      |
|                                                  |                                                               |                                               |
| 0% no ded                                        | 0% no ded                                                     | 0% no ded                                     |
| 0% no ded                                        | 0% no ded                                                     | 0% no ded                                     |
| \$750 no ded                                     | \$750 no ded                                                  | \$750 no ded                                  |
|                                                  |                                                               |                                               |
| 0% after ded                                     | Visits 1 – 3: \$40 copay no ded*<br>Visits 4+ : 0% after ded* | \$50 no ded                                   |
| 0% after ded                                     | 0% after ded                                                  | \$100 no ded                                  |
| 0% after ded                                     | 0% no ded                                                     | \$0 no ded                                    |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
| 0% after ded/0% after ded                        | 0% after ded/0% after ded                                     | \$100 no ded/\$100 no ded                     |
|                                                  |                                                               |                                               |
| 0% after ded                                     | 0% after ded                                                  | Subject to ded and \$700 per day <sup>7</sup> |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
| 0% after ded                                     | 0% after ded                                                  | Subject to ded and \$500 copay                |
| 0% after ded/0% after ded                        | 0% after ded/0% after ded                                     | \$120 no ded/\$120 no ded                     |
| 0% after ded/0% after ded                        | 0% after ded/0% after ded                                     | \$250 no ded/\$250 no ded                     |
| 0% after ded/0% after ded                        | 0% after ded/0% after ded                                     | 50% after ded/50% after ded                   |
| 0% after ded/0% after ded                        | 0% after ded/0% after ded                                     | 50% after ded/50% after ded                   |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
| 0% after ded                                     | Visits 1 – 3: \$40 copay no ded<br>Visits 4+ : 0% after ded   | \$100 no ded                                  |
| 0% after ded                                     | 0% after ded                                                  | Subject to ded and \$700 per day <sup>7</sup> |
|                                                  |                                                               |                                               |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |
|                                                  |                                                               |                                               |
| 0% after ded                                     | 0% after ded                                                  | 0% no ded                                     |
| 0% after ded                                     | 0% after ded                                                  | 0% no ded                                     |
|                                                  |                                                               |                                               |
| Integrated with medical ded                      | Integrated with medical ded                                   | Integrated with medical ded                   |
| 0% after ded <sup>16</sup>                       | 0% after ded <sup>16</sup>                                    | \$15 after ded <sup>16,19</sup>               |
| 0% after ded <sup>16</sup>                       | 0% after ded <sup>16</sup>                                    | 50% after ded up to \$300 <sup>16</sup>       |
| 0% after ded <sup>16</sup>                       | 0% after ded <sup>16</sup>                                    | 50% after ded up to \$400 <sup>16</sup>       |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded up to \$1,000                   |
|                                                  |                                                               |                                               |
|                                                  |                                                               |                                               |
| \$0 no ded                                       | \$0 no ded                                                    | \$0 no ded                                    |
|                                                  |                                                               |                                               |
| Integrated with medical ded                      | Integrated with medical ded                                   | \$50                                          |
| 0% no ded                                        | 0% no ded                                                     | \$0 no ded                                    |
| 0% after ded                                     | 0% after ded                                                  | 50% after ded                                 |

OFF These plans are not offered on HealthCare.gov and must be purchased through Independence directly.

Footnotes begin on page 43 | ded = Deductible

Questions? Contact your broker for assistance.

| Catastrophic                                                                                   | Personal Choice <sup>®</sup> EPO Catastrophic <sup>2</sup> |
|------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup>                            |
| Ded, individual/family                                                                         | \$8,150/16,300                                             |
| Coinsurance                                                                                    | 0%                                                         |
| Out-of-pocket maximum, individual/family includes:                                             | \$8,150/\$16,300 copay, ded and coinsurance                |
| Preventive services <sup>5</sup>                                                               |                                                            |
| Preventive care for adults and children                                                        | 0% no ded                                                  |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | 0% no ded                                                  |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750 no ded                                               |
| Physician services                                                                             |                                                            |
| Primary care office visit/retail clinic                                                        | Visits 1–3: \$50 copay no ded*<br>Visits 4+: 0% after ded* |
| Specialist office visit                                                                        | 0% after ded                                               |
| Telemedicine <sup>28</sup>                                                                     | 0% after ded                                               |
| Urgent care                                                                                    | 0% after ded                                               |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | 0% after ded                                               |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | 0% after ded/0% after ded                                  |
| Hospital/other medical services                                                                |                                                            |
| Inpatient hospital services (includes maternity)                                               | 0% after ded                                               |
| Inpatient professional services (includes maternity)                                           | 0% after ded                                               |
| Emergency room (not waived if admitted)                                                        | 0% after ded                                               |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | 0% after ded/0% after ded                                  |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | 0% after ded/0% after ded                                  |
| Biotech/specialty injectables — Home, office/outpatient                                        | 0% after ded/0% after ded                                  |
| Infusion — Home, office/outpatient                                                             | 0% after ded/0% after ded                                  |
| Durable medical equipment/prosthetics                                                          | 0% after ded                                               |
| Mental health, serious mental illness & substance abuse — outpatient                           | Visits 1 – 3: \$50 copay no ded<br>Visits 4+: 0% after ded |
| Mental health, serious mental illness & substance abuse — inpatient                            | 0% after ded                                               |
| Outpatient surgery                                                                             |                                                            |
| Ambulatory surgical facility                                                                   | 0% after ded                                               |
| Hospital-based                                                                                 | 0% after ded                                               |
| Outpatient lab/pathology                                                                       |                                                            |
| Freestanding                                                                                   | 0% after ded                                               |
| Hospital-based                                                                                 | 0% after ded                                               |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |                                                            |
| Rx ded (individual/family)                                                                     | Integrated with medical ded                                |
| Retail generic <sup>16</sup>                                                                   | 0% after ded                                               |
| Retail preferred brand <sup>16,18</sup>                                                        | 0% after ded                                               |
| Retail non-preferred drug <sup>16,18</sup>                                                     | 0% after ded                                               |
| Specialty <sup>18</sup>                                                                        | 0% after ded                                               |
| Additional benefits                                                                            |                                                            |
| Vision <sup>20,21</sup>                                                                        |                                                            |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0 no ded                                                 |
| Dental <sup>24,25</sup>                                                                        |                                                            |
| Pediatric dental ded (per individual)                                                          | Integrated with medical ded                                |
| Pediatric exams and cleanings <sup>26</sup>                                                    | 0% no ded                                                  |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 0% after ded                                               |

2020

# Cost-Share Reduction Plans

Enroll in a Cost-Share Reduction (or CSR) health plan on HealthCare.gov if you qualify for both lower monthly premiums and lower out-of-pocket costs (see p. 3 for more information). Contact your broker if you want help determining your eligibility or applying.



Independence 



| Silver 200 – 249% CSR plans                                                                    | Personal Choice® EPO Silver Reserve <sup>2</sup> |
|------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup>                  |
| Ded, individual/family <sup>10</sup>                                                           | \$2,800/\$5,600                                  |
| Coinsurance                                                                                    | 20% unless otherwise noted                       |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                               | \$4,900/\$9,800<br>copay, ded, and coinsurance   |
| Preventive services <sup>5</sup>                                                               |                                                  |
| Preventive care for adults and children                                                        | 0% no ded                                        |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | 0% no ded                                        |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$750 no ded                                     |
| Physician services                                                                             |                                                  |
| Primary care office visit/retail clinic <sup>13</sup>                                          | \$20 after ded                                   |
| Specialist office visit                                                                        | \$50 after ded                                   |
| Telemedicine <sup>28</sup>                                                                     | 20% after ded                                    |
| Urgent care                                                                                    | 20% after ded                                    |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | 20% after ded                                    |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$50 after ded/\$50 after ded                    |
| Hospital/other medical services                                                                |                                                  |
| Inpatient hospital services (includes maternity)                                               | 20% after ded                                    |
| Inpatient professional services (includes maternity)                                           | 20% after ded                                    |
| Emergency room (not waived if admitted)                                                        | 20% after ded                                    |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | 20% after ded/20% after ded                      |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | 20% after ded/20% after ded                      |
| Biotech/specialty injectables — Home, office/outpatient                                        | 20% after ded/20% after ded                      |
| Infusion — Home, office/outpatient                                                             | 20% after ded/20% after ded                      |
| Durable medical equipment/prosthetics                                                          | 20% after ded                                    |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$50 after ded                                   |
| Mental health, serious mental illness & substance abuse — inpatient                            | 20% after ded                                    |
| Outpatient surgery                                                                             |                                                  |
| Ambulatory surgical facility                                                                   | 20% after ded                                    |
| Hospital-based                                                                                 | 20% after ded                                    |
| Outpatient lab/pathology                                                                       |                                                  |
| Freestanding                                                                                   | 20% after ded                                    |
| Hospital-based                                                                                 | 20% after ded                                    |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |                                                  |
| Rx ded (individual/family)                                                                     | Integrated with medical ded                      |
| Retail generic                                                                                 | 20% after ded <sup>16</sup>                      |
| Retail preferred brand <sup>18</sup>                                                           | 20% after ded <sup>16</sup>                      |
| Retail non-preferred drug <sup>18</sup>                                                        | 20% after ded <sup>16</sup>                      |
| Specialty <sup>18</sup>                                                                        | 50% after ded with \$1,000                       |
| Additional benefits                                                                            |                                                  |
| Vision <sup>20,21</sup>                                                                        |                                                  |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0 no ded                                       |
| Dental <sup>24,25</sup>                                                                        |                                                  |
| Pediatric dental ded (per individual)                                                          | Integrated with medical ded                      |
| Pediatric exams and cleanings <sup>26</sup>                                                    | 0% no ded                                        |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 20% after ded                                    |

Personal Choice® PPO Silver<sup>2</sup>

| You pay in-network                              | You pay out-of-network <sup>4</sup>      |
|-------------------------------------------------|------------------------------------------|
| \$2,750/\$5,500                                 | \$10,000/\$20,000                        |
| 20% unless otherwise noted                      | 50% unless otherwise noted               |
| \$6,500/\$13,000<br>copay, ded, and coinsurance | \$20,000/\$40,000<br>ded and coinsurance |
| 0% no ded                                       | 50% no ded                               |
| 0% no ded                                       | n/a                                      |
| \$750 no ded                                    | 50% no ded                               |
| \$30 no ded                                     | 50% after ded                            |
| \$70 no ded                                     | 50% after ded                            |
| \$20 no ded                                     | Not covered                              |
| 20% after ded                                   | 50% after ded                            |
| 20% after ded                                   | 50% after ded                            |
| \$70 no ded/\$70 no ded                         | 50% after ded/50% after ded              |
| 20% after ded                                   | 50% after ded                            |
| 20% after ded                                   | 50% after ded                            |
| 20% after ded                                   | 20% after in-network ded                 |
| 20% after ded/20% after ded                     | 50% after ded/50% after ded              |
| 20% after ded/20% after ded                     | 50% after ded/50% after ded              |
| 20% after ded/20% after ded                     | 50% after ded/50% after ded              |
| 20% after ded/20% after ded                     | 50% after ded/50% after ded              |
| 20% after ded                                   | 50% after ded                            |
| \$70 no ded                                     | 50% after ded                            |
| 20% after ded                                   | 50% after ded                            |
| 20% after ded                                   | 50% after ded                            |
| 0% no ded                                       | 50% after ded                            |
| 50% no ded                                      | 50% after ded                            |
| Integrated with medical ded                     | Integrated with medical ded              |
| \$15 no ded <sup>16,19</sup>                    | 70% no ded                               |
| 40% after ded up to \$200 <sup>16</sup>         | 70% after ded                            |
| 50% after ded up to \$200 <sup>16</sup>         | 70% after ded                            |
| 50% after ded up to \$1,000                     | Not covered                              |
| \$0 no ded                                      | Not covered                              |
| \$50                                            | n/a                                      |
| \$0 no ded                                      | Not covered                              |
| 50% after ded                                   | Not covered                              |

| Silver 200 – 249% CSR plans                                                                      | Keystone HMO Silver Proactive <sup>2</sup>            |                                                      |                                                      |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                          | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| Ded, individual/family <sup>10</sup>                                                             | \$0/\$0                                               | \$6,000/\$12,000                                     | \$6,000/\$12,000                                     |
| Coinsurance                                                                                      | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                                 | \$6,500/\$13,000<br>copay and coinsurance             | \$6,500/\$13,000<br>copay, ded, and coinsurance      | \$6,500/\$13,000<br>copay, ded, and coinsurance      |
| Preventive services <sup>5</sup>                                                                 |                                                       |                                                      |                                                      |
| Preventive care for adults and children                                                          | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers               | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                          | \$750                                                 | \$750 no ded                                         | \$750 no ded                                         |
| Physician services                                                                               |                                                       |                                                      |                                                      |
| Primary care office visit/retail clinic <sup>13</sup>                                            | \$40                                                  | \$60 no ded                                          | \$70 no ded                                          |
| Specialist office visit                                                                          | \$80                                                  | \$120 no ded                                         | \$140 no ded                                         |
| Telemedicine <sup>28</sup>                                                                       | \$20                                                  | \$20 no ded                                          | \$20 no ded                                          |
| Urgent care                                                                                      | \$100                                                 | \$100 no ded                                         | \$100 no ded                                         |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                           | \$50                                                  | \$50 no ded                                          | \$50 no ded                                          |
| Physical/occupational therapy (30 visits per year) —<br>Freestanding/Hospital-based <sup>6</sup> | \$80/\$80                                             | \$80 no ded/\$80 no ded                              | \$80 no ded/\$80 no ded                              |
| Hospital/other medical services                                                                  |                                                       |                                                      |                                                      |
| Inpatient hospital services (includes maternity)                                                 | \$600 per day <sup>7</sup>                            | Subject to ded and \$900 per day <sup>7</sup>        | Subject to ded and \$1,300 per day <sup>7</sup>      |
| Inpatient professional services (includes maternity)                                             | 0%                                                    | 5% after ded                                         | 10% after ded                                        |
| Emergency room (not waived if admitted) <sup>12</sup>                                            | \$550 <sup>12</sup>                                   | \$550 no ded <sup>12</sup>                           | \$550 no ded <sup>12</sup>                           |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                       | \$120/\$120                                           | \$120 no ded/\$120 no ded                            | \$120 no ded/\$120 no ded                            |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                     | \$250/\$250                                           | \$250 no ded/\$250 no ded                            | \$250 no ded/\$250 no ded                            |
| Biotech/specialty injectables — Home, office/outpatient                                          | 50%/50%                                               | 50% no ded/50% no ded                                | 50% no ded/50% no ded                                |
| Infusion — Home, office/outpatient                                                               | 0%/0%                                                 | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| Durable medical equipment/prosthetics                                                            | 50%                                                   | 50% no ded                                           | 50% no ded                                           |
| Mental health, serious mental illness & substance abuse — outpatient                             | \$80                                                  | \$80 no ded                                          | \$80 no ded                                          |
| Mental health, serious mental illness & substance abuse — inpatient                              | \$600 per day <sup>7</sup>                            | \$600 per day no ded <sup>7</sup>                    | \$600 per day no ded <sup>7</sup>                    |
| Outpatient surgery                                                                               |                                                       |                                                      |                                                      |
| Ambulatory surgical facility                                                                     | \$250                                                 | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Hospital-based                                                                                   | \$250                                                 | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Outpatient lab/pathology                                                                         |                                                       |                                                      |                                                      |
| Freestanding                                                                                     | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Hospital-based                                                                                   | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Prescription drugs <sup>14,15,17,1</sup>                                                         |                                                       |                                                      |                                                      |
| Rx ded (individual/family) <sup>4</sup>                                                          | \$250/\$500                                           | \$250/\$500                                          | \$250/\$500                                          |
| Retail generic <sup>16,19</sup>                                                                  | \$20 no ded <sup>16,19</sup>                          | \$20 no ded <sup>16,19</sup>                         | \$20 no ded <sup>16,19</sup>                         |
| Retail preferred brand <sup>16,18</sup>                                                          | 50% after ded up to \$400 <sup>16</sup>               | 50% after ded up to \$400 <sup>16</sup>              | 50% after ded up to \$400 <sup>16</sup>              |
| Retail non-preferred drug <sup>16,18</sup>                                                       | 50% after ded up to \$500 <sup>16</sup>               | 50% after ded up to \$500 <sup>16</sup>              | 50% after ded up to \$500 <sup>16</sup>              |
| Specialty <sup>18</sup>                                                                          | 50% after ded up to \$1,000                           | 50% after ded up to \$1,000                          | 50% after ded up to \$1,000                          |
| Additional benefits                                                                              |                                                       |                                                      |                                                      |
| Vision <sup>20,21</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                              | \$0                                                   | \$0 no ded                                           | \$0 no ded                                           |
| Dental <sup>24,25</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric dental ded (per individual)                                                            | \$50                                                  | \$50                                                 | \$50                                                 |
| Pediatric exams and cleanings <sup>26</sup>                                                      | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                   | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |



Keystone HMO Silver Proactive Lite<sup>2</sup>

| You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| \$2,000/\$4,000                                       | \$6,500/\$13,000                                     | \$6,500/\$13,000                                     |
| 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| \$6,500/\$13,000<br>copay, ded, and coinsurance       | \$6,500/\$13,000<br>copay, ded, and coinsurance      | \$6,500/\$13,000<br>copay, ded, and coinsurance      |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$750 no ded                                          | \$750 no ded                                         | \$750 no ded                                         |
| \$50 no ded                                           | \$60 no ded                                          | \$70 no ded                                          |
| \$100 no ded                                          | \$120 no ded                                         | \$140 no ded                                         |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| \$100 no ded                                          | \$100 no ded                                         | \$100 no ded                                         |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$100 no ded/\$100 no ded                             | \$100 no ded/\$100 no ded                            | \$100 no ded/\$100 no ded                            |
| Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$900 per day <sup>7</sup>        | Subject to ded and \$1,300 per day <sup>7</sup>      |
| 0% after ded                                          | 5% after ded                                         | 10% after ded                                        |
| \$600 no ded                                          | \$600 no ded                                         | \$600 no ded                                         |
| \$150 no ded/\$150 no ded                             | \$150 no ded/\$150 no ded                            | \$150 no ded/\$150 no ded                            |
| \$250 no ded/\$250 no ded                             | \$250 no ded/\$250 no ded                            | \$250 no ded/\$250 no ded                            |
| 50% no ded/50% no ded                                 | 50% no ded/50% no ded                                | 50% no ded/50% no ded                                |
| 0% after ded/0% after ded                             | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| 50% no ded                                            | 50% no ded                                           | 50% no ded                                           |
| \$100 no ded                                          | \$100 no ded                                         | \$100 no ded                                         |
| Subject to ded and \$600 per day <sup>7</sup>         | Subject to ded and \$600 per day <sup>7</sup>        | Subject to ded and \$600 per day <sup>7</sup>        |
| Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| Subject to ded and \$250 copay                        | Subject to ded and \$750 copay                       | Subject to ded and \$1,250 copay                     |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$250/\$500                                           | \$250/\$500                                          | \$250/\$500                                          |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| 50% after ded up to \$400                             | 50% after ded up to \$400                            | 50% after ded up to \$400                            |
| 50% after ded up to \$500                             | 50% after ded up to \$500                            | 50% after ded up to \$500                            |
| 50% after ded up to \$1,000                           | 50% after ded up to \$1,000                          | 50% after ded up to \$1,000                          |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

| Silver 150 – 199% CSR plans                                                                    | Personal Choice® EPO Silver Reserve <sup>2</sup> |
|------------------------------------------------------------------------------------------------|--------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                        | You pay in-network <sup>3</sup>                  |
| Ded, individual/family <sup>10</sup>                                                           | \$500/\$1,000                                    |
| Coinsurance                                                                                    | 15% unless otherwise noted                       |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                               | \$2,700/\$5,400<br>copay, ded, and coinsurance   |
| Preventive services <sup>5</sup>                                                               |                                                  |
| Preventive care for adults and children                                                        | 0% no ded                                        |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers             | 0% no ded                                        |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                        | \$500 no ded                                     |
| Physician services                                                                             |                                                  |
| Primary care office visit/retail clinic <sup>13</sup>                                          | \$20 after ded                                   |
| Specialist office visit                                                                        | \$50 after ded                                   |
| Telemedicine <sup>28</sup>                                                                     | 15% after ded                                    |
| Urgent care                                                                                    | 15% after ded                                    |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                         | 15% after ded                                    |
| Physical/occupational therapy (30 visits per year)<br>Freestanding/Hospital-based <sup>6</sup> | \$50 after ded/\$50 after ded                    |
| Hospital/other medical services                                                                |                                                  |
| Inpatient hospital services (includes maternity)                                               | 15% after ded                                    |
| Inpatient professional services (includes maternity)                                           | 15% after ded                                    |
| Emergency room (not waived if admitted)                                                        | 15% after ded                                    |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                     | 15% after ded/15% after ded                      |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                   | 15% after ded/15% after ded                      |
| Biotech/specialty injectables — Home, office/outpatient                                        | 15% after ded/15% after ded                      |
| Infusion — Home, office/outpatient                                                             | 15% after ded/15% after ded                      |
| Durable medical equipment/prosthetics                                                          | 15% after ded                                    |
| Mental health, serious mental illness & substance abuse — outpatient                           | \$50 after ded                                   |
| Mental health, serious mental illness & substance abuse — inpatient                            | 15% after ded                                    |
| Outpatient surgery                                                                             |                                                  |
| Ambulatory surgical facility                                                                   | 15% after ded                                    |
| Hospital-based                                                                                 | 15% after ded                                    |
| Outpatient lab/pathology                                                                       |                                                  |
| Freestanding                                                                                   | 15% after ded                                    |
| Hospital-based                                                                                 | 15% after ded                                    |
| Prescription drugs <sup>14,15,17,1</sup>                                                       |                                                  |
| Rx ded (individual/family)                                                                     | Integrated with medical ded                      |
| Retail generic                                                                                 | 15% after ded <sup>16</sup>                      |
| Retail preferred brand <sup>18</sup>                                                           | 15% after ded <sup>16</sup>                      |
| Retail non-preferred drug <sup>18</sup>                                                        | 15% after ded <sup>16</sup>                      |
| Specialty <sup>18</sup>                                                                        | 50% after ded up to \$500                        |
| Additional benefits                                                                            |                                                  |
| <b>Vision</b> <sup>20,21</sup>                                                                 |                                                  |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                            | \$0 no ded                                       |
| <b>Dental</b> <sup>24,25</sup>                                                                 |                                                  |
| Pediatric dental ded (per individual)                                                          | Integrated with medical ded                      |
| Pediatric exams and cleanings <sup>26</sup>                                                    | 0% no ded                                        |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                 | 15% after ded                                    |

Personal Choice® PPO Silver<sup>2</sup>

| You pay in-network                             | You pay out-of-network <sup>4</sup>      |
|------------------------------------------------|------------------------------------------|
| \$2,500/\$5,000                                | \$10,000/\$20,000                        |
| 10% unless otherwise noted                     | 50% unless otherwise noted               |
| \$2,700/\$5,400<br>copay, ded, and coinsurance | \$20,000/\$40,000<br>ded and coinsurance |
| 0% no ded                                      | 50% no ded                               |
| 0% no ded                                      | n/a                                      |
| \$500 no ded                                   | 50% no ded                               |
| \$25 no ded                                    | 50% after ded                            |
| \$50 no ded                                    | 50% after ded                            |
| \$20 no ded                                    | Not covered                              |
| 10% after ded                                  | 50% after ded                            |
| 10% after ded                                  | 50% after ded                            |
| \$50 no ded/\$50 no ded                        | 50% after ded/50% after ded              |
| 10% no ded                                     | 50% after ded                            |
| 10% no ded                                     | 50% after ded                            |
| 10% no ded                                     | 10% no ded                               |
| 10% no ded/10% no ded                          | 50% after ded/50% after ded              |
| 10% no ded/10% no ded                          | 50% after ded/50% after ded              |
| 10% after ded/10% after ded                    | 50% after ded/50% after ded              |
| 10% after ded/10% after ded                    | 50% after ded/50% after ded              |
| 10% after ded                                  | 50% after ded                            |
| \$50 no ded                                    | 50% after ded                            |
| 10% no ded                                     | 50% after ded                            |
| 10% no ded                                     | 50% after ded                            |
| 0% no ded                                      | 50% after ded                            |
| 50% no ded                                     | 50% after ded                            |
| Integrated with medical ded                    | Integrated with medical ded              |
| \$10 no ded <sup>16</sup>                      | 70% no ded                               |
| 40% after ded up to \$200 <sup>16</sup>        | 70% after ded                            |
| 50% after ded up to \$200 <sup>16</sup>        | 70% after ded                            |
| 50% after ded up to \$500                      | Not covered                              |
| \$0 no ded                                     | Not covered                              |
| \$50                                           | n/a                                      |
| \$0 no ded                                     | Not covered                              |
| 50% after ded                                  | Not covered                              |

| Silver 150 – 199% CSR plans                                                                      | Keystone HMO Silver Proactive <sup>2</sup>            |                                                      |                                                      |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                          | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| Ded, individual/family <sup>10</sup>                                                             | \$0/\$0                                               | \$1,750/\$3,500                                      | \$1,750/\$3,500                                      |
| Coinsurance                                                                                      | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                                 | \$2,700/\$5,400<br>copay and coinsurance              | \$2,700/\$5,400<br>copay, ded, and coinsurance       | \$2,700/\$5,400<br>copay, ded, and coinsurance       |
| Preventive services <sup>5</sup>                                                                 |                                                       |                                                      |                                                      |
| Preventive care for adults and children                                                          | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers               | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                          | \$500                                                 | \$500 no ded                                         | \$500 no ded                                         |
| Physician services                                                                               |                                                       |                                                      |                                                      |
| Primary care office visit/retail clinic <sup>13</sup>                                            | \$20                                                  | \$30 no ded                                          | \$40 no ded                                          |
| Specialist office visit                                                                          | \$40                                                  | \$60 no ded                                          | \$80 no ded                                          |
| Telemedicine <sup>28</sup>                                                                       | \$20                                                  | \$20 no ded                                          | \$20 no ded                                          |
| Urgent care                                                                                      | \$50                                                  | \$50 no ded                                          | \$50 no ded                                          |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                           | \$50                                                  | \$50 no ded                                          | \$50 no ded                                          |
| Physical/occupational therapy (30 visits per year) —<br>Freestanding/Hospital-based <sup>6</sup> | \$40/\$40                                             | \$40 no ded/\$40 no ded                              | \$40 no ded/\$40 no ded                              |
| Hospital/other medical services                                                                  |                                                       |                                                      |                                                      |
| Inpatient hospital services (includes maternity)                                                 | \$200 per day <sup>7</sup>                            | Subject to ded and \$500 per day <sup>7</sup>        | Subject to ded and \$900 per day <sup>7</sup>        |
| Inpatient professional services (includes maternity)                                             | 0%                                                    | 5% after ded                                         | 10% after ded                                        |
| Emergency room (not waived if admitted) <sup>12</sup>                                            | \$200 <sup>12</sup>                                   | \$200 no ded <sup>12</sup>                           | \$200 no ded <sup>12</sup>                           |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                       | \$50/\$50                                             | \$50 no ded/\$50 no ded                              | \$50 no ded/\$50 no ded                              |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                     | \$100/\$100                                           | \$100 no ded/\$100 no ded                            | \$100 no ded/\$100 no ded                            |
| Biotech/specialty injectables — Home, office/outpatient                                          | 40%/40%                                               | 40% no ded/40% no ded                                | 40% no ded/40% no ded                                |
| Infusion — Home, office/outpatient                                                               | 0%/0%                                                 | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| Durable medical equipment/prosthetics                                                            | 20%                                                   | 20% no ded                                           | 20% no ded                                           |
| Mental health, serious mental illness & substance abuse — outpatient                             | \$40                                                  | \$40 no ded                                          | \$40 no ded                                          |
| Mental health, serious mental illness & substance abuse — inpatient                              | \$200 per day <sup>7</sup>                            | \$200 per day no ded <sup>7</sup>                    | \$200 per day no ded <sup>7</sup>                    |
| Outpatient surgery                                                                               |                                                       |                                                      |                                                      |
| Ambulatory surgical facility                                                                     | \$100                                                 | Subject to ded and \$450 copay                       | Subject to ded and \$900 copay                       |
| Hospital-based                                                                                   | \$100                                                 | Subject to ded and \$450 copay                       | Subject to ded and \$900 copay                       |
| Outpatient lab/pathology                                                                         |                                                       |                                                      |                                                      |
| Freestanding                                                                                     | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Hospital-based                                                                                   | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Prescription drugs <sup>14,15,17,1</sup>                                                         |                                                       |                                                      |                                                      |
| Rx ded (individual/family)                                                                       | None                                                  | None                                                 | None                                                 |
| Retail generic <sup>16,19</sup>                                                                  | \$10 <sup>16</sup>                                    | \$10 <sup>16</sup>                                   | \$10 <sup>16</sup>                                   |
| Retail preferred brand <sup>16,18</sup>                                                          | 30% up to \$300 <sup>16</sup>                         | 30% up to \$300 <sup>16</sup>                        | 30% up to \$300 <sup>16</sup>                        |
| Retail non-preferred drug <sup>16,18</sup>                                                       | 40% up to \$400 <sup>16</sup>                         | 40% up to \$400 <sup>16</sup>                        | 40% up to \$400 <sup>16</sup>                        |
| Specialty <sup>18</sup>                                                                          | 50% up to \$500                                       | 50% up to \$500                                      | 50% up to \$500                                      |
| Additional benefits                                                                              |                                                       |                                                      |                                                      |
| Vision <sup>20,21</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                              | \$0                                                   | \$0 no ded                                           | \$0 no ded                                           |
| Dental <sup>24,25</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric dental ded (per individual)                                                            | \$50                                                  | \$50                                                 | \$50                                                 |
| Pediatric exams and cleanings <sup>26</sup>                                                      | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                   | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

Keystone HMO Silver Proactive Lite<sup>2</sup>

| You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| \$ 1,000/\$2,000                                      | \$2,000/\$4,000                                      | \$2,000/\$4,000                                      |
| 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| \$2,700/\$5,400<br>copay, ded, and coinsurance        | \$2,700/\$5,400<br>copay, ded, and coinsurance       | \$2,700/\$5,400<br>copay, ded, and coinsurance       |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$500 no ded                                          | \$500 no ded                                         | \$500 no ded                                         |
| \$20 no ded                                           | \$30 no ded                                          | \$40 no ded                                          |
| \$40 no ded                                           | \$60 no ded                                          | \$80 no ded                                          |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$40 no ded/\$40 no ded                               | \$40 no ded/\$40 no ded                              | \$40 no ded/\$40 no ded                              |
| Subject to ded and \$300 per day <sup>7</sup>         | Subject to ded and \$500 per day <sup>7</sup>        | Subject to ded and \$900 per day <sup>7</sup>        |
| 0% after ded                                          | 5% after ded                                         | 10% after ded                                        |
| \$250 no ded                                          | \$250 no ded                                         | \$250 no ded                                         |
| \$50 no ded/\$50 no ded                               | \$50 no ded/\$50 no ded                              | \$50 no ded/\$50 no ded                              |
| \$100 no ded/\$100 no ded                             | \$100 no ded/\$100 no ded                            | \$100 no ded/\$100 no ded                            |
| 40% no ded/40% no ded                                 | 40% no ded/40% no ded                                | 40% no ded/40% no ded                                |
| 0% after ded/0% after ded                             | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| 20% no ded                                            | 20% no ded                                           | 20% no ded                                           |
| \$40 no ded                                           | \$40 no ded                                          | \$40 no ded                                          |
| Subject to ded and \$300 per day <sup>7</sup>         | Subject to ded and \$300 per day <sup>7</sup>        | Subject to ded and \$300 per day <sup>7</sup>        |
| Subject to ded and \$100 copay                        | Subject to ded and \$450 copay                       | Subject to ded and \$900 copay                       |
| Subject to ded and \$100 copay                        | Subject to ded and \$450 copay                       | Subject to ded and \$900 copay                       |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| None                                                  | None                                                 | None                                                 |
| \$10                                                  | \$10                                                 | \$10                                                 |
| 30% up to \$300                                       | 30% up to \$300                                      | 30% up to \$300                                      |
| 40% up to \$400                                       | 40% up to \$400                                      | 40% up to \$400                                      |
| 50% up to \$500                                       | 50% up to \$500                                      | 50% up to \$500                                      |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |



## Silver 138 – 149% CSR plans

### Benefits per calendar year<sup>1</sup>

Ded, individual/family<sup>10</sup>

Coinsurance

Out-of-pocket maximum, individual/family includes:<sup>11</sup>

### Preventive services<sup>5</sup>

Preventive care for adults and children

Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers

Preventive colonoscopy for colorectal cancer screening — Hospital-based

### Physician services

Primary care office visit/retail clinic<sup>13</sup>

Specialist office visit

Telemedicine<sup>28</sup>

Urgent care

Spinal manipulations (20 visits per year)<sup>6</sup>

Physical/occupational therapy (30 visits per year)  
Freestanding/Hospital-based<sup>6</sup>

### Hospital/other medical services

Inpatient hospital services (includes maternity)

Inpatient professional services (includes maternity)

Emergency room (not waived if admitted)

Routine radiology/diagnostic — Freestanding/Hospital-based

MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based

Biotech/specialty injectables — Home, office/outpatient

Infusion — Home, office/outpatient

Durable medical equipment/prosthetics

Mental health, serious mental illness & substance abuse — outpatient

Mental health, serious mental illness & substance abuse — inpatient

### Outpatient surgery

Ambulatory surgical facility

Hospital-based

### Outpatient lab/pathology

Freestanding

Hospital-based

### Prescription drugs<sup>14,15,17,1</sup>

Rx ded (individual/family)

Retail generic

Retail preferred brand<sup>18</sup>

Retail non-preferred drug<sup>18</sup>

Specialty<sup>18</sup>

### Additional benefits

Vision<sup>20,21</sup>

Pediatric exam & pediatric eyewear<sup>22,23</sup>

Dental<sup>24,25</sup>

Pediatric dental ded (per individual)

Pediatric exams and cleanings<sup>26</sup>

Pediatric basic, major, and orthodontia services<sup>27</sup>

## Personal Choice® EPO Silver Reserve<sup>2</sup>

### You pay in-network<sup>3</sup>

\$100/\$200

5% unless otherwise noted

\$2,700/\$5,400  
copay, ded, and coinsurance

0% no ded

0% no ded

\$250 no ded

\$10 after ded

\$30 after ded

5% after ded

5% after ded

5% after ded

\$30 after ded/\$30 after ded

5% after ded

5% after ded

5% after ded

5% after ded/5% after ded

5% after ded/5% after ded

5% after ded/5% after ded

5% after ded/5% after ded

5% after ded

\$30 after ded

5% after ded

5% after ded

5% after ded

5% after ded

5% after ded

Integrated with medical ded

5% after ded<sup>16</sup>

5% after ded<sup>16</sup>

5% after ded<sup>16</sup>

50% after ded up to \$500

\$0 no ded

Integrated with medical ded

0% no ded

5% after ded

Personal Choice® PPO Silver<sup>2</sup>

| You pay in-network                       | You pay out-of-network <sup>4</sup>      |
|------------------------------------------|------------------------------------------|
| \$0/\$0                                  | \$10,000/\$20,000                        |
| 10% unless otherwise noted               | 50% unless otherwise noted               |
| \$2,700/\$5,400<br>copay and coinsurance | \$20,000/\$40,000<br>ded and coinsurance |
|                                          |                                          |
| \$0                                      | 50% no ded                               |
| \$0                                      | n/a                                      |
| \$250                                    | 50% no ded                               |
|                                          |                                          |
| \$5                                      | 50% after ded                            |
| \$10                                     | 50% after ded                            |
| \$20                                     | Not covered                              |
| 10%                                      | 50% after ded                            |
| 10%                                      | 50% after ded                            |
| \$10/\$10                                | 50% after ded/50% after ded              |
|                                          |                                          |
| 10%                                      | 50% after ded                            |
| 10%                                      | 50% after ded                            |
| 10%                                      | 10% no ded                               |
| 10%/10%                                  | 50% after ded/50% after ded              |
| 10%/10%                                  | 50% after ded/50% after ded              |
| 10%/10%                                  | 50% after ded/50% after ded              |
| 10%/10%                                  | 50% after ded/50% after ded              |
| 10%                                      | 50% after ded                            |
| \$10                                     | 50% after ded                            |
| 10%                                      | 50% after ded                            |
|                                          |                                          |
| 10%                                      | 50% after ded                            |
| 10%                                      | 50% after ded                            |
|                                          |                                          |
| 0%                                       | 50% after ded                            |
| 50%                                      | 50% after ded                            |
|                                          |                                          |
| None                                     | None                                     |
| \$4 <sup>16</sup>                        | 70%                                      |
| 15% up to \$200 <sup>16</sup>            | 70%                                      |
| 15% up to \$200 <sup>16</sup>            | 70%                                      |
| 50% up to \$500                          | Not covered                              |
|                                          |                                          |
| \$0                                      | Not covered                              |
|                                          |                                          |
| \$50                                     | n/a                                      |
| \$0 no ded                               | Not covered                              |
| 50% after ded                            | Not covered                              |

| Silver 138 – 149% CSR plans                                                                      | Keystone HMO Silver Proactive <sup>2</sup>            |                                                      |                                                      |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| Benefits per calendar year <sup>1</sup>                                                          | You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
| Ded, individual/family <sup>10</sup>                                                             | \$0/\$0                                               | \$200/\$400                                          | \$200/\$400                                          |
| Coinsurance                                                                                      | 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| Out-of-pocket maximum, individual/family includes: <sup>11</sup>                                 | \$2,100/\$4,200<br>copay and coinsurance              | \$2,100/\$4,200<br>copay, ded, and coinsurance       | \$2,100/\$4,200<br>copay, ded, and coinsurance       |
| Preventive services <sup>5</sup>                                                                 |                                                       |                                                      |                                                      |
| Preventive care for adults and children                                                          | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers               | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based                          | \$250                                                 | \$250 no ded                                         | \$250 no ded                                         |
| Physician services                                                                               |                                                       |                                                      |                                                      |
| Primary care office visit/retail clinic <sup>13</sup>                                            | \$5                                                   | \$10 no ded                                          | \$20 no ded                                          |
| Specialist office visit                                                                          | \$15                                                  | \$20 no ded                                          | \$40 no ded                                          |
| Telemedicine <sup>28</sup>                                                                       | \$20                                                  | \$20 no ded                                          | \$20 no ded                                          |
| Urgent care                                                                                      | \$25                                                  | \$25 no ded                                          | \$25 no ded                                          |
| Spinal manipulations (20 visits per year) <sup>6</sup>                                           | \$50                                                  | \$50 no ded                                          | \$50 no ded                                          |
| Physical/occupational therapy (30 visits per year) —<br>Freestanding/Hospital-based <sup>6</sup> | \$15/\$15                                             | \$15 no ded/\$15 no ded                              | \$15 no ded/\$15 no ded                              |
| Hospital/other medical services                                                                  |                                                       |                                                      |                                                      |
| Inpatient hospital services (includes maternity)                                                 | \$50 per day <sup>7</sup>                             | Subject to ded and \$250 per day <sup>7</sup>        | Subject to ded and \$500 per day <sup>7</sup>        |
| Inpatient professional services (includes maternity)                                             | 0%                                                    | 5% after ded                                         | 10% after ded                                        |
| Emergency room (not waived if admitted) <sup>12</sup>                                            | \$50 <sup>12</sup>                                    | \$50 no ded <sup>12</sup>                            | \$50 no ded <sup>12</sup>                            |
| Routine radiology/diagnostic — Freestanding/Hospital-based                                       | \$10/\$10                                             | \$10 no ded/\$10 no ded                              | \$10 no ded/\$10 no ded                              |
| MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based                                     | \$20/\$20                                             | \$20 no ded/\$20 no ded                              | \$20 no ded/\$20 no ded                              |
| Biotech/specialty injectables — Home, office/outpatient                                          | 40%/40%                                               | 40% no ded/40% no ded                                | 40% no ded/40% no ded                                |
| Infusion — Home, office/outpatient                                                               | 0%/0%                                                 | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| Durable medical equipment/prosthetics                                                            | 20%                                                   | 20% no ded                                           | 20% no ded                                           |
| Mental health, serious mental illness & substance abuse — outpatient                             | \$15                                                  | \$15 no ded                                          | \$15 no ded                                          |
| Mental health, serious mental illness & substance abuse — inpatient                              | \$50 per day <sup>7</sup>                             | \$50 per day no ded <sup>7</sup>                     | \$50 per day no ded <sup>7</sup>                     |
| Outpatient surgery                                                                               |                                                       |                                                      |                                                      |
| Ambulatory surgical facility                                                                     | \$50                                                  | Subject to ded and \$200 copay                       | Subject to ded and \$400 copay                       |
| Hospital-based                                                                                   | \$50                                                  | Subject to ded and \$200 copay                       | Subject to ded and \$400 copay                       |
| Outpatient lab/pathology                                                                         |                                                       |                                                      |                                                      |
| Freestanding                                                                                     | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Hospital-based                                                                                   | 0%                                                    | 0% no ded                                            | 0% no ded                                            |
| Prescription drugs <sup>14,15,17,1</sup>                                                         |                                                       |                                                      |                                                      |
| Rx ded (individual/family)                                                                       | None                                                  | None                                                 | None                                                 |
| Retail generic <sup>16,19</sup>                                                                  | \$4 <sup>16</sup>                                     | \$4 <sup>16</sup>                                    | \$4 <sup>16</sup>                                    |
| Retail preferred brand <sup>16,18</sup>                                                          | 5% up to \$300 <sup>16</sup>                          | 5% up to \$300 <sup>16</sup>                         | 5% up to \$300 <sup>16</sup>                         |
| Retail non-preferred drug <sup>16,18</sup>                                                       | 5% up to \$400 <sup>16</sup>                          | 5% up to \$400 <sup>16</sup>                         | 5% up to \$400 <sup>16</sup>                         |
| Specialty <sup>18</sup>                                                                          | 30% up to \$500                                       | 30% up to \$500                                      | 30% up to \$500                                      |
| Additional benefits                                                                              |                                                       |                                                      |                                                      |
| Vision <sup>20,21</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric exam & pediatric eyewear <sup>22,23</sup>                                              | \$0                                                   | \$0 no ded                                           | \$0 no ded                                           |
| Dental <sup>24,25</sup>                                                                          |                                                       |                                                      |                                                      |
| Pediatric dental ded (per individual)                                                            | \$50                                                  | \$50                                                 | \$50                                                 |
| Pediatric exams and cleanings <sup>26</sup>                                                      | \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| Pediatric basic, major, and orthodontia services <sup>27</sup>                                   | 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

Keystone HMO Silver Proactive Lite<sup>2</sup>

| You pay in-network <sup>3</sup><br>Tier 1 – Preferred | You pay in-network <sup>3</sup><br>Tier 2 – Enhanced | You pay in-network <sup>3</sup><br>Tier 3 – Standard |
|-------------------------------------------------------|------------------------------------------------------|------------------------------------------------------|
| \$50/\$100                                            | \$200/\$400                                          | \$200/\$400                                          |
| 0% unless otherwise noted                             | 5% unless otherwise noted                            | 10% unless otherwise noted                           |
| \$2,100/\$4,200<br>copay, ded, and coinsurance        | \$2,100/\$4,200<br>copay, ded, and coinsurance       | \$2,100/\$4,200<br>copay, ded, and coinsurance       |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| \$250 no ded                                          | \$250 no ded                                         | \$250 no ded                                         |
| \$5 no ded                                            | \$10 no ded                                          | \$20 no ded                                          |
| \$15 no ded                                           | \$20 no ded                                          | \$40 no ded                                          |
| \$20 no ded                                           | \$20 no ded                                          | \$20 no ded                                          |
| \$25 no ded                                           | \$25 no ded                                          | \$25 no ded                                          |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$15 no ded/\$15 no ded                               | \$15 no ded/\$15 no ded                              | \$15 no ded/\$15 no ded                              |
| Subject to ded and \$50 per day <sup>7</sup>          | Subject to ded and \$250 per day <sup>7</sup>        | Subject to ded and \$500 per day <sup>7</sup>        |
| 0% after ded                                          | 5% after ded                                         | 10% after ded                                        |
| \$50 no ded                                           | \$50 no ded                                          | \$50 no ded                                          |
| \$10 no ded/\$10 no ded                               | \$10 no ded/\$10 no ded                              | \$10 no ded/\$10 no ded                              |
| \$20 no ded/\$20 no ded                               | \$20 no ded/\$20 no ded                              | \$20 no ded/\$20 no ded                              |
| 40% no ded/40% no ded                                 | 40% no ded/40% no ded                                | 40% no ded/40% no ded                                |
| 0% after ded/0% after ded                             | 5% after ded/5% after ded                            | 10% after ded/10% after ded                          |
| 20% no ded                                            | 20% no ded                                           | 20% no ded                                           |
| \$15 no ded                                           | \$15 no ded                                          | \$15 no ded                                          |
| Subject to ded and \$50 per day <sup>7</sup>          | Subject to ded and \$50 per day <sup>7</sup>         | Subject to ded and \$50 per day <sup>7</sup>         |
| Subject to ded and \$50 copay                         | Subject to ded and \$200 copay                       | Subject to ded and \$400 copay                       |
| Subject to ded and \$50 copay                         | Subject to ded and \$200 copay                       | Subject to ded and \$400 copay                       |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| 0% no ded                                             | 0% no ded                                            | 0% no ded                                            |
| None                                                  | None                                                 | None                                                 |
| \$4                                                   | \$4                                                  | \$4                                                  |
| 5% up to \$300                                        | 5% up to \$300                                       | 5% up to \$300                                       |
| 5% up to \$400                                        | 5% up to \$400                                       | 5% up to \$400                                       |
| 30% up to \$500                                       | 30% up to \$500                                      | 30% up to \$500                                      |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| \$50                                                  | \$50                                                 | \$50                                                 |
| \$0 no ded                                            | \$0 no ded                                           | \$0 no ded                                           |
| 50% after ded                                         | 50% after ded                                        | 50% after ded                                        |

2020

# Adult dental and vision plans

Pediatric dental and vision coverage is included in all Independence medical plans. For adults 19 and older, standalone vision and dental plans are available throughout the year with or without enrollment in a medical plan.

Independence 



## Choose your adult dental plan

**Adult Dental Preferred** is the plan for you if you're looking for an adult dental plan that covers preventive services (like exams and cleanings) and basic services (like fillings and root canals).

**Adult Dental Premier** is the plan for you if you're looking to get the added protection of lower out-of-pocket costs and coverage for major services, such as crowns and dentures.

|                                                  | Adult Dental Preferred                                                                                                    | Adult Dental Premier <sup>29</sup>                                    |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| One-time annual deductible                       | \$50 individual; \$150 family                                                                                             | \$50 individual; \$150 family                                         |
| Annual maximum benefit                           | \$1,000 per covered member                                                                                                | \$1,000 per covered member                                            |
| <b>Start using these services right away</b>     |                                                                                                                           |                                                                       |
| Exams                                            | Covered at 100%, no deductible, no waiting period 1 per 12 months                                                         | Covered at 100%, no deductible, no waiting period 1 per 6 months      |
| Cleanings                                        | Covered at 100%, no deductible, no waiting period 1 per 12 months                                                         | Covered at 100%, no deductible, no waiting period 1 per 6 months      |
| Bitewing X-rays                                  | Covered at 100%, no deductible, no waiting period 1 set per 24 months, ages 19 – 29; 1 set per 3 years, ages 30 and older | Covered at 100%, no deductible, no waiting period 1 set per 18 months |
| Full mouth X-rays                                | Covered at 100%, no deductible, no waiting period 1 per 5 years (new patients only)                                       | Covered at 100%, no deductible, no waiting period 1 per 5 years       |
| Fillings, extractions                            | 50% after deductible No waiting period                                                                                    | 20% after deductible No waiting period                                |
| <b>You'll get these benefits after 12 months</b> |                                                                                                                           |                                                                       |
| Root canals, periodontics, oral surgery          | 50% after deductible 12 month waiting period for new members                                                              | 20% after deductible 12 month waiting period for new members          |
| Crown and denture repair                         | 50% after deductible 12 month waiting period for new members                                                              | 20% after deductible 12 month waiting period for new members          |
| Crowns and dentures                              | Not covered N/A                                                                                                           | 50% after deductible 12 month waiting period for new members          |

### Adult dental plans — Monthly premiums per member

| Age     | Adult Dental Preferred | Adult Dental Premier |
|---------|------------------------|----------------------|
| 19 – 25 | \$17.55                | \$31.42              |
| 26 – 39 | \$18.65                | \$33.38              |
| 40 – 49 | \$21.94                | \$39.27              |
| 50 – 63 | \$25.78                | \$46.14              |
| 64 +    | \$26.33                | \$47.12              |



# Choose an adult vision plan

|                                                                                                              | Vision Care 100                                        | Vision Care 180                                                                                |
|--------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|------------------------------------------------------------------------------------------------|
| In-network benefits                                                                                          | You pay                                                | You pay                                                                                        |
| Frequency (exam and hardware)                                                                                | Once every calendar year                               | Once every calendar year                                                                       |
| Copays for exam and lenses                                                                                   | \$0                                                    | \$0                                                                                            |
| Frame                                                                                                        |                                                        |                                                                                                |
| Davis Vision Exclusive Frame Collection (instead of allowance):                                              |                                                        |                                                                                                |
| • Fashion selection                                                                                          | \$0 copay                                              | \$0 copay                                                                                      |
| • Designer selection                                                                                         | \$15 copay                                             | \$0 copay                                                                                      |
| • Premier selection                                                                                          | \$40 copay                                             | \$25 copay                                                                                     |
| Non-collection frame allowance                                                                               | Up to \$100, 20% discount on average <sup>30</sup>     | Up to \$130, or up to \$180 <sup>31</sup> at Visionworks, 20% discount on average <sup>1</sup> |
| Lens options                                                                                                 | You pay                                                | You pay                                                                                        |
| Clear plastic single-vision, lined bifocal, trifocal, or lenticular lenses (any Rx)                          | \$0                                                    | \$0                                                                                            |
| Tinting of plastic lenses                                                                                    | \$15                                                   | \$0                                                                                            |
| Scratch-resistant coating                                                                                    | \$0                                                    | \$0                                                                                            |
| Polycarbonate lenses                                                                                         | \$35                                                   | \$30                                                                                           |
| Ultraviolet coating                                                                                          | \$0                                                    | \$0                                                                                            |
| Anti-reflective (AR) coating                                                                                 | \$40/\$55/\$69                                         | \$35/\$48/\$60                                                                                 |
| Progressive lenses                                                                                           | \$65/\$105/\$140                                       | \$50/\$90/\$140                                                                                |
| High-index lenses                                                                                            | \$60                                                   | \$55                                                                                           |
| Transition lenses (plastic photosensitive)                                                                   | \$70                                                   | \$65                                                                                           |
| Polarized lenses                                                                                             | \$75                                                   | \$75                                                                                           |
| Contact lens benefit (instead of eyeglasses)                                                                 | Benefit                                                | Benefit                                                                                        |
| Davis Vision Contact Lens Collection (instead of allowance)                                                  |                                                        |                                                                                                |
| • Disposable                                                                                                 | Not covered                                            | 4 boxes/multi-packs                                                                            |
| • Planned replacement                                                                                        | Not covered                                            | 2 boxes/multi-packs                                                                            |
| • Evaluation, fitting, and follow-up care                                                                    | Not covered                                            | Included                                                                                       |
| Non-collection contact lenses: Materials allowance                                                           | Up to \$100, plus 15% discount on average <sup>1</sup> | Up to \$130, plus 15% discount on average <sup>1</sup>                                         |
| Medically necessary contact lenses (with prior approval): Materials, evaluation, fitting, and follow-up care | Included                                               | Included                                                                                       |
| Out of network                                                                                               | Reimbursable amount (up to)                            | Reimbursable amount (up to)                                                                    |
| Eye examination                                                                                              | \$40                                                   | \$40                                                                                           |
| Frame                                                                                                        | \$50                                                   | \$50                                                                                           |
| Lenses: single/bifocal/trifocal/lenticular                                                                   | \$40/\$60/\$80/\$100                                   | \$40/\$60/\$80/\$100                                                                           |
| Elective contact lenses                                                                                      | \$80                                                   | \$105                                                                                          |
| Medically necessary contact lenses                                                                           | \$225                                                  | \$225                                                                                          |

## Adult vision plans — Monthly premiums

| Family tier                         | Vision Care 100 | Vision Care 180 |
|-------------------------------------|-----------------|-----------------|
| Individual                          | \$13.21         | \$14.17         |
| Individual + one dependent          | \$26.41         | \$28.33         |
| Individual + two or more dependents | \$39.62         | \$42.50         |

# Health plan footnotes

## Medical

\* Retail clinic services are subject to 0 percent coinsurance after deductible.

- 1 Certain plan benefits may be enhanced to comply with health care reform law/regulations. Eligible dependent children are covered to age 26.
- 2 Embedded Deductible: Family deductible and out-of-pocket maximum apply when more than one person is covered under a plan. A covered family member only needs to satisfy his or her individual deductible before receiving plan benefits. Once the family deductible is met, then all covered family members will receive plan benefits. A covered family member only needs to satisfy his or her out-of-pocket maximum before that individual's benefits are covered in full. Once the family out-of-pocket is met, then all covered family members' benefits will be covered in full.
- 3 There are no out-of-network services available except for emergency services.
- 4 Out-of-Network providers may bill you for differences between the Plan allowance, which is the amount paid by Independence, and the actual charge of the provider. This amount may be significant. Claims payments for out-of-network providers are based on the lesser of the Medicare Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, payment is based on the lesser of the Independence applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is based on 50 percent of the actual charge of the provider with the exception of inpatient facility services. For inpatient facility covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is determined by Independence's fee schedule for the closest analogous covered service.
- 5 Age and frequency schedules may apply. In order to get a preventive colonoscopy without having to pay any out-of-pocket costs, you must choose Preventive Plus providers and GI professionals (gastroenterologists or colon and rectal surgeons) that are not hospital-based to perform the preventive colonoscopy. To find a Preventive Plus provider, visit [ibx.com/findadoctor](http://ibx.com/findadoctor).
- 6 For PPO plans, visit limits are combined in- and out-of-network.
- 7 Amount shown reflects the copay per day. There is a maximum of five copays per admission.
- 8 For this plan, inpatient maternity hospital services are subject to 30 percent coinsurance after deductible.
- 9 For PPO Bronze, inpatient maternity hospital services are subject to 50 percent coinsurance after deductible.

## Keystone HMO Proactive

- 10 For Keystone HMO Silver Proactive the deductible is combined for Tiers 2 and 3.
- 11 For all Keystone HMO Proactive plans, the out-of-pocket maximum for Tiers 1, 2, and 3 are combined.
- 12 For Keystone HMO Proactive plans, if you are admitted to an in-network hospital from the emergency room, the out-of-pocket costs for inpatient hospital will apply based on the tier of the in-network hospital. If admitted to an out-of-network hospital following an emergency room admission, the Tier 3 in-network level of benefits will apply. Out-of-network providers for emergency services will be covered at the Tier 3 level of benefits.
- 13 For Keystone HMO Proactive plans, all in-network retail clinics are assigned to Tier 1, with the exception of Rite Aid Redi Clinic, which is assigned to Tier 3.

## Prescription drugs

- 14 Prescription drug benefits are administered by FutureScripts, an independent company providing pharmacy benefit management services.
- 15 No cost-sharing is required at participating retail and mail order pharmacies for certain preventive drugs (prescription and over-the-counter drugs with a doctor's prescription).
- 16 Out-of-network benefits apply to prescriptions filled at non-participating pharmacies and the member must pay the full retail price for their prescription and then file a paper claim for reimbursement. The member should refer to their benefit booklet to determine the out-of-network coverage for their plan.

- 17 This plan utilizes the FutureScripts Preferred Pharmacy Network — a subset of the national retail pharmacy network. It includes over 59,000 pharmacies, including most major chains and local pharmacies except Rite Aid. With plans that use the Preferred Pharmacy network, filling a prescription at a non-participating pharmacy is considered out-of-network, and members must pay the total cost upfront. They may be able to get reimbursed for part of this cost, but they will need to submit a claim and reimbursement will be at a lower rate.
- 18 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and the member will be responsible for the cost-sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If the member purchases a brand drug, the member will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate cost-sharing for a brand drug.
- 19 Certain designated generic drugs are available at participating retail and mail order pharmacies for a reduced member cost-sharing (\$4 retail / \$8 mail order), after any applicable deductible.
  - † For all plans, member pays cost-sharing per each fill unless out-of-pocket max has been met.
  - ‡ Embedded Deductible: Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. Once an individual meets the individual deductible amount, claims for that individual will pay. Once the family deductible is met, claims for all individuals will pay. Once an individual meets the individual out-of-pocket maximum, benefits for that individual are covered in full. Once the family out-of-pocket maximum is met, benefits for all family members are covered in full. Individual deductible and out-of-pocket maximum apply when an individual is enrolled without dependents.

## Additional benefits

- 20 Independence vision plans are administered by Davis Vision, an independent company.
- 21 Pediatric vision benefits expire at the end of the month in which the child turns 19.
- 22 One eye exam per calendar year period.
- 23 Pediatric spectacle lenses covered at no extra cost include: single vision, lined bifocal, lined trifocal, or lenticular lenses. For frames to be covered in full, choose from Davis Vision's Pediatric Frame Selection (available at most independent participating providers). Davis Vision Contact Lenses Collection is covered in full at participating independent providers.
- 24 Independence dental plans are administered by United Concordia Companies, Inc., an independent company.
- 25 Pediatric dental benefits are covered until the end of the calendar year in which the child turns 19.
- 26 One exam and one cleaning every six months per calendar year.
- 27 Only medically necessary orthodontia is covered.
- 28 Independence telemedicine benefits are administered by MDLIVE, an independent company.

## Adult dental and vision

- 29 With the Adult Dental Premier plan, the amount that the plan pays for these services is not deducted from the annual benefit maximum.
- 30 Discount not available at Walmart, Sam's Club, and Costco.
- 31 Enhanced frame allowance available at all Visionworks locations nationwide. Only available with Vision Care 180 plan.

# Coverage for American Indians/ Alaskan Natives



## Are you an American Indian or Alaskan Native?

If you're a member of a federally recognized tribe, you are eligible for Platinum, Gold, Silver, and Bronze plans with similar or no cost-sharing based on whether your household income is more or less than 300% of the Federal Poverty Level (FPL).

### Less than 300% FPL plan options

You may choose from any of the Standard plan options on pages 15–25, but you will have \$0 cost-sharing for all covered services. You may also qualify for a premium tax credit (subsidy).

### More than 300% FPL plan options

You may choose from any of the Standard plan options on pages 15–25 and you will pay the cost-sharing amounts listed, but you will have \$0 cost-sharing if you receive care for any essential health benefits that are referred by or received directly from the HIS, Indian Tribe, Tribal Organization, or Urban Indian Organization. You may also qualify for a premium tax credit.

#### Household Income

| Family size  | Less than 300% FPL | More than 300% FPL |
|--------------|--------------------|--------------------|
| Single       | \$37,469.99        | \$37,470.00        |
| Family of 2  | \$50,729.99        | \$50,730.00        |
| Family of 3  | \$63,989.99        | \$63,990.00        |
| Family of 4  | \$77,249.99        | \$77,250.00        |
| Family of 5  | \$90,509.99        | \$90,510.00        |
| Family of 6  | \$103,769.99       | \$103,770.00       |
| Family of 7  | \$117,029.99       | \$117,030.00       |
| Family of 8* | \$130,289.99       | \$130,290.00       |

\* For more than eight, add this amount for each additional person: \$4,420. This chart is intended to give you an idea if you will be eligible for help in paying your health insurance costs depending on your income, and household size. Final eligibility determinations and the actual amount of your tax credit will be determined by the federal government.

Source: <https://aspe.hhs.gov/poverty-guidelines>

## Keystone HMO Proactive hospital tier placements

### Tier 1 – Preferred \$

#### Pennsylvania

##### Bucks

Aria Health — Bucks County Campus  
Doylestown Hospital  
Grand View Hospital  
Lower Bucks Hospital  
Rothman Orthopaedic Specialty Hospital  
St. Luke's Health Network — Quakertown Campus

##### Chester

Chester County Hospital  
Tower Health — Brandywine Hospital  
Tower Health — Jennersville Regional Hospital  
Tower Health — Phoenixville Hospital

##### Delaware

Crozer-Chester Medical Center  
Delaware County Memorial Hospital  
Springfield Hospital  
Taylor Hospital

##### Lehigh

St. Luke's Health Network — Allentown Campus  
St. Luke's Health Network — Bethlehem Campus

##### Montgomery

Abington Memorial Hospital  
Albert Einstein Medical Center —  
Montgomery Campus  
Holy Redeemer Hospital and Medical Center  
Lansdale Hospital  
Suburban Community Hospital  
Tower Health — Pottstown Memorial  
Medical Center

##### Philadelphia

Albert Einstein Medical Center  
Albert Einstein Medical Center —  
Germantown Campus  
Aria Health — Frankford Campus  
Aria Health — Torresdale Campus  
Jeanes Hospital  
Roxborough Memorial Hospital  
Tower Health — Chestnut Hill Hospital  
Wills Eye Hospital

#### New Jersey

##### Burlington

Deborah Heart & Lung Center  
Virtua Willingboro Hospital

##### Camden

Cooper Hospital University Medical Center

##### Mercer

Robert Wood Johnson University Hospital  
at Hamilton  
St. Francis Medical Center

##### Salem

Memorial Hospital of Salem County

##### Warren

Hackettstown Community Hospital

### Tier 2 – Enhanced \$\$

#### Pennsylvania

##### Philadelphia

Children's Hospital of Philadelphia  
Fox Chase Cancer Center  
St. Christopher's Hospital for Children  
Shriners' Hospital for Children

#### New Jersey

##### Camden

Virtua Our Lady of Lourdes Hospital

##### Gloucester

Inspira Medical Center — Woodbury

#### Delaware

##### New Castle

A.I. DuPont Hospital for Children

### Tier 3 – Standard \$\$\$

#### Pennsylvania

##### Berks

St. Joseph Medical Center  
Tower Health — Reading Hospital and  
Medical Center

##### Bucks

St. Mary Medical Center

##### Chester

Main Line Health — Paoli Hospital

##### Delaware

Main Line Health — Riddle Hospital

##### Lancaster

Ephrata Community Hospital  
Lancaster General Hospital

##### Lehigh

Lehigh Valley Hospital  
Lehigh Valley Hospital — Muhlenberg  
Sacred Heart Hospital

##### Montgomery

Main Line Health — Bryn Mawr  
Hospital  
Main Line Health — Lankenau  
Medical Center

##### Philadelphia

Hospital of the University of  
Pennsylvania  
Mercy Fitzgerald Hospital  
Mercy Philadelphia Hospital  
Methodist Hospital  
Nazareth Hospital  
Penn Presbyterian Medical Center  
Pennsylvania Hospital  
Temple — Northeast Campus  
Temple University Hospital  
Thomas Jefferson  
University Hospital

#### New Jersey

##### Burlington

Virtua Marlton Hospital  
Virtua Memorial Hospital

##### Camden

Kennedy University Hospitals —  
Cherry Hill Division  
Kennedy University Hospitals —  
Stratford Division  
Kennedy University Hospitals —  
Washington Township Division  
Virtua Voorhees Hospital

##### Hunterdon

Hunterdon Medical Center

##### Mercer

Capital Health System — Fuld Campus  
Capital Health System —  
Hopewell Campus

#### Delaware

##### Salem

Inspira Medical Center — Elmer

##### Warren

St. Luke's Health Network —  
Warren Hospital

##### New Castle

Christiana Care Health System —  
Christiana Hospital  
Christiana Care Health System —  
Wilmington Hospital  
St. Francis Hospital

#### Maryland

##### Cecil

Union Hospital

Occasionally updates are made to our network and tier placements. Visit [ibx.com/findadoctor](https://ibx.com/findadoctor) for the latest information. Be sure to select *Keystone HMO Proactive* under Your Plan to see the tiers.

# Important plan information

## Benefits that require preapproval

When you need services that require preapproval, your physician or provider contacts the Independence Blue Cross Clinical Services team and provides information to support the request for services. For PPO members using a BlueCard® PPO or out-of-network provider, the member is responsible for contacting Clinical Services directly for any required approvals. For EPO members using a BlueCard® PPO provider, the member is responsible for contacting Clinical Services directly for any required approvals. The Clinical Services team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The Clinical Services team notifies your physician/provider if the services are approved for coverage. If the Clinical Services team does not have sufficient information or the information evaluated does not support coverage, you and your physician/provider are notified in writing of the decision. Members and providers acting on behalf of a member may appeal the decision. At any time during the evaluation process or the appeal, the provider or member may provide additional information to support the request.

For a list of services that require preapproval, visit [ibx.com/importantinfo](https://ibx.com/importantinfo).

## Inpatient hospital stays

During and after an approved hospital stay, our Care Management and Coordination team monitors your stay. The team reviews whether you are receiving medically appropriate care, sees that a plan for your discharge is in place, and coordinates services that may be needed following discharge.

## Utilization review

In order to make coverage determinations regarding the medical necessity and appropriateness of requested services, we use medical guidelines based on clinically credible evidence. This is called utilization review. Utilization review can be done before a service is performed (prenotification/precertification/preservice); during a hospital stay (concurrent review); or after services have been performed (retrospective/post-service review). Independence Blue Cross follows applicable state/federal standards pertaining to how and when these reviews are performed.

## Continuity of care

(Continuity of care policy applies to HMO plans only)

### Terminated providers

Independence Blue Cross offers members continuation of coverage for an ongoing course of treatment with a terminated provider (for reasons other than cause) for up to 90 days from the date that we notified the member of the provider termination. We will cover such continuing treatment under the same terms and conditions as if the treatment was being received from participating providers.

If a member is in her second or third trimester of pregnancy at the time of the termination, the transitional period of authorization shall extend through post-partum care related to the delivery. All authorized health care services provided during this transitional period would be covered by Independence Blue Cross under the same terms and conditions applicable for participating health care providers. The nonparticipating provider must agree that all authorized health care services provided during this transitional period would be covered by Independence Blue Cross under the same terms and conditions applicable for participating health care providers. The plan is not required to provide health care services that are not covered benefits.

In order to initiate continuity of care, members must complete a Continuity of Care form and submit it to our Care Management and Coordination department. The form is available through Customer Service.

## Emergency services

An emergency is defined as the sudden and unexpected onset of a medical condition manifesting itself in acute symptoms of sufficient severity or severe pain that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the member's health or, in the case of a pregnant member, the health of the unborn child in jeopardy
- Serious impairment to bodily functions
- Dysfunction of any bodily organ or part

Emergency care includes covered services provided to a member in an emergency, including emergency transportation and related emergency services provided by a licensed ambulance service.

## Complaints and grievances

You have a right to appeal any adverse decision through the Complaints and Grievances Process. Instructions for the appeal will be described in the denial notifications and in the contract.

## Privacy policy

Protecting your privacy is very important to us. That is why we have taken numerous steps to see that your Protected Health Information (PHI) is kept confidential. PHI is individually identifiable health information about you. This information may be in oral, written, or electronic form. Independence Blue Cross may obtain or create your PHI while conducting our business of providing you with health care benefits. To view information and documentation related to privacy and HIPAA (the Health Insurance Portability and Accountability Act of 1996), visit [ibx.com/privacy](http://ibx.com/privacy) or call us at 215-241-4735 or 1-888-678-7005 (toll-free).

Independence Blue Cross has implemented policies and procedures regarding the collection, use, and release or disclosure of PHI by and within our organization. We continually review our policies and monitor our business processes to make sure that your information is protected while assuring that the information is available as needed for the provision of health care services. For detailed information on our privacy policy, visit [ibx.com/importantinfo](http://ibx.com/importantinfo).

## Prescription drug guidelines

Our prescription drug plans are administered by FutureScripts, an independent pharmacy benefits management company who is responsible for providing a network of participating pharmacies, administering benefits, conducting prior authorization reviews, and providing customer service. Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. We support a number of procedures to support safe prescribing, including:

**Prior authorization** — This means that you may need additional approval from your health plan for a certain medication. Certain covered drugs require prior authorization to ensure that the drug prescribed is medically necessary and appropriate and is being prescribed according to the U.S. Food and Drug Administration's (FDA) guidelines.

**Age limits** — The FDA has established specific procedures that govern prescription prescribing practices. These rules are designed to prevent potential harm to patients and ensure that the medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals age 14 and older.

**Quantity limits** — These are designed to allow a sufficient supply of medication based upon FDA-approved maximum daily doses and length of therapy of a particular drug. There are several different types of quantity limits, such as rolling 30-day period, refill too soon, and therapeutic drug class.

**96-hour temporary supply program** — Under this program, if a member's doctor writes a prescription for a drug that requires prior authorization, has an age limit, or exceeds the quantity limit for a medication, and prior authorization has not been obtained by the doctor, a 96-hour supply of the drug will be made available while the request is being reviewed. Obtaining a 96-hour temporary supply does not guarantee that the prior authorization request will be approved.

To learn more about safe prescribing procedures, see a list of drugs requiring prior authorization, find out what's covered by your plan, or find out how to file a request or appeal, visit [ibx.com/rx](http://ibx.com/rx) or contact your broker.



## Important Plan Information continued

### Exception process

Your doctor may request coverage for a drug that is not on the formulary after a trial of covered drugs on the Value Formulary, or if there are medical reasons that you cannot use other covered drugs. Your doctor must submit an exception request that describes your need for the drug that is not covered on the formulary. Your doctor should fax the request to 1-888-671-5285. If your doctor does not receive a response in two business days, please call FutureScripts at 1-888-678-7012.

If the exception request is approved, the drug will be covered at the highest cost-share as listed in your benefits. Certain limits, such as quantity limits and age limits, will still apply. If the request is denied, you and your doctor will receive a denial letter. The letter will explain how to file an appeal, if you wish to appeal the decision.

### Prescription drug program provider payment information

A pharmacy benefits management (PBM) company administers our prescription drug benefits and is responsible for providing a network of participating pharmacies and processing pharmacy claims. The PBM also negotiates price discounts with pharmaceutical manufacturers and provides drug utilization and quality reviews. Price discounts may include rebates from a drug manufacturer based on the volume purchased. Independence Blue Cross anticipates that it will pass on a high percentage of the expected rebates it receives from its PBM through reductions in the overall cost of pharmacy benefits. Under most benefits plans, prescription drugs are subject to a member copayment.

### Benefits exclusions

**The benefits summaries in this brochure represent only a partial listing of benefits and exclusions of the plans. Benefits and exclusions may be further defined by medical policy.**

This managed care plan may not cover all your health care expenses. Read your contract carefully to determine which health care services are covered. If you need more information, please contact your broker.

What's not covered?

- Services not medically necessary
- Services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Alternative therapies, such as acupuncture
- Adult dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Bariatric or obesity surgery
- Routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Outpatient services that are not performed by your primary care physician's designated provider for HMO plans
- Private duty nursing
- Self-injectable drugs are excluded under medical programs (however, they are covered under the prescription drug benefit)
- Adult routine eye care
- Pleoptic/orthoptic

NOTE: Eligible dependent children are generally covered up to age 26. See contract for additional details. To obtain complete copies of these policies by mail, please call 1-866-346-2081 (TTY: 711).

# Glossary



**Coinsurance** – The percentage you pay for some covered services. If your coinsurance is 20 percent, your health insurance company will pay 80 percent of the cost of covered services; you will pay the remaining 20 percent (your costs are usually based on a discounted amount negotiated by your insurance company).

**Copay** – The flat fee you pay when you see a doctor or receive other services. For example, your health plan may have a \$20 copay to see a doctor.

**Cost-sharing** – Also known as out-of-pocket costs, this is the money you pay in the form of a copay, deductible, or coinsurance when you receive care. This is separate from the monthly premium you pay to be a member of the health plan.

**Deductible** – The amount you pay each year before your health plan starts paying for covered services. For example, if your plan has a \$1,000 deductible, you will need to pay the first \$1,000 of the costs for the health care services you receive. Once you have paid this amount, your insurance will begin to pay a portion or all of your health care costs, depending on the health plan.

**Health Savings Account (HSA)** – An HSA is a type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses.

**In network** – The doctors, hospitals, labs, and other health care providers that contract with a health insurance company to deliver services to members. They usually charge discounted rates for their services. To keep it simple, we'll just refer to them as doctors and hospitals throughout this brochure.

**Out of network** – Doctors, hospitals, labs, and other health care providers who do not have a contract with a health insurance company. Members typically pay more for services from out-of-network providers. Certain health plans do not cover services from out-of-network providers (e.g., HMO and EPO plans).

**Out-of-pocket maximum** – An out-of-pocket maximum is the most you will have to pay for your health care expenses during a plan period (usually a year) for covered services received from in-network providers. No matter what, you will not pay more than this amount each year. Any care for covered services you get after you meet your out-of-pocket maximum will be covered 100 percent by the health insurer. Monthly premiums do not count towards your out-of-pocket maximum.

**Premium** – Also known as a monthly rate, this is the money you pay to your insurance company each month to have health insurance. This is separate from the copays, deductibles, and coinsurance you pay when you need care.

**Preventive care** – Services that help you stay healthy and may also detect some diseases in the early stages. Examples include flu shots, mammograms, colonoscopies, and cholesterol tests.

**Primary care physician (PCP)** – Another term for your family doctor.

**Referral** – If you have an HMO plan, your primary care physician will need to provide you with a referral before you see other in-network providers, such as a heart doctor (cardiologist).

**Specialist** – A specialist provides care for certain conditions in addition to the treatment provided by your primary care physician. For example, you may need to see an allergist for allergies or an orthopedic surgeon for a knee injury.

**Tax credit (subsidy)** – Financial assistance from the government to help pay for your health insurance costs.

## Language Assistance Services

**Spanish:** ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

**Chinese:** 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

**Korean:** 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

**Portuguese:** ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

**Gujarati:** સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કોલ કરો.

**Vietnamese:** LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

**Russian:** ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

**Italian:** ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

**Arabic:** ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

**French Creole:** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

**Pennsylvania Dutch:** BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

**Hindi:** ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

**Japanese:** 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

### Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

**Navajo:** Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh. Hódííłnih koji' 1-800-275-2583.

### Urdu:

توجہ درکار ہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

**Mon-Khmer, Cambodian:** សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះ ជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

## Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: [civilrightscordinator@1901market.com](mailto:civilrightscordinator@1901market.com). If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.





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