



2026 Health Plans

For Individuals and Families

Independence 

We're glad you're considering Independence Blue Cross!

Choosing a health plan is a big decision. Take some time to review the information in this book. You'll learn about the plans we offer and how to enroll.

If you have any questions or want us to help you find a plan that works for your health needs and budget, we're here for you! Here's how you can reach us:



Online at **ibx.com/answers**



By phone at
1-855-640-3454 (TTY: 711)



In person at **Independence LIVE**

1919 Market Street, 2nd Floor
Philadelphia, PA 19103
See our hours at **ibx.com/events**.



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Philly, we've got you

Independence Blue Cross (IBX) has called Philadelphia home for more than 85 years. As your hometown health insurer, IBX has worked hard to make health insurance easier, so you can focus on what matters most to you.

Why choose IBX? IBX knows Philly better than any other health insurance company. Like you, we live here and work here. And we rely on the quality and security of our IBX health plan to keep our families safe and healthy. We continually look for innovative ways to meet the evolving needs of our members and offer health plans that fit your life.

More Philadelphians choose IBX than any other health plan.

Choose IBX to get:

- The largest network in the region, no matter what plan you choose
- Affordable, convenient, high-quality care options
- Support for all of you, including your physical and mental health



Apply for a plan
and experience the
difference IBX makes.

How to apply for a plan

Ready to enroll in medical, dental, or vision insurance — or all three?
There are several ways to apply and pay.

Enrolling in a plan

There are 3 ways to enroll:



ONLINE

Visit ibx.com/applynow to get started.



BY PHONE

Call **1-855-640-3454** (TTY: 711).



BY MAIL

Send your application to:
Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

Payment options

Never miss a payment! We make it easy, with several ways to pay. You must pay your first month's premium before your coverage goes into effect, and you must make monthly premium payments for your coverage to continue. Your payment options include:

eBill

With eBill, you can save a stamp and don't need to worry about late payments. Log in at ibx.com or on the IBX app up to 30 days before your coverage start date. It's free and easy to set up automatic recurring payments. Note: You'll need to set up payments for each plan you purchase (medical, dental, vision). Visit ibx.com/payment or call **1-855-640-3454 (TTY: 711)** for instructions.

Check or money order

You can mail a personal check or money order to pay your first month's premium. To make ongoing payments by check, you will receive a bill each month before your payment is due. Separate checks are required for medical, dental, and vision plans and should be made payable to Independence Blue Cross. Please refer to your bill for the payment remittance address, and include payment coupons and the account number on each check.

By phone

To make a payment using our automated system, call **1-888-879-4891 (TTY: 711)**. You can provide your bank account information or use a prepaid debit card. There are no fees for this service.

In person at Independence LIVE

To make a payment in person, visit Independence LIVE at 1919 Market Street, 2nd floor, Philadelphia PA, 19103. See our hours at ibx.com/events.

Health plans that fit your life

We offer a wide variety of health plans, so you can find one that fits your needs, preferences, and budget. No matter what health plan you choose, you always have access to the full IBX provider network.

All IBX health plans cover the same essential health benefits, including doctor visits, hospital stays, prescription drug coverage, blood tests, X-rays, preventive care, and more. You also get access to unlimited virtual care for a \$0* copay.

Our provider network is what sets us apart from other health insurers. IBX offers the strongest network of doctors and hospitals in the region, so it is very likely that your local doctors are in the network.†

Our network also includes a broad selection of high-quality behavioral health providers across many specialties (both in-person and virtual). Read more on page 15.

* Cost-sharing may apply for Catastrophic and HSA-qualified health plans.

† Zelis Network Comparison Reports, November 2024

60,000+ in-network doctors

180+ in-network hospitals

65,000+ in-network pharmacies (Standard Rx network)

\$0 copay for virtual visits from Teladoc*



Meet our health plans

Individuals and families can choose from three levels of health plans: Gold, Silver, and Bronze. We also offer a Catastrophic health plan for people younger than 30 or for those who qualify for a special exemption.



	G Gold	S Silver	B Bronze
Monthly premium	\$\$\$	\$\$	\$
Out-of-pocket costs	\$	\$\$	\$\$\$
Good option if you ...	Plan to use a lot of health care services	See doctors and specialists occasionally	Don't plan to use a lot of health care services

The differences between health plans are in the monthly premium, if a deductible applies, and out-of-pocket costs when you receive covered services.

Our most popular plans: Keystone HMO Proactive

Keystone HMO Proactive health plans are our most popular for good reason. Your monthly premium is lower, and you can save even more when you use Tier 1 doctors and hospitals.

How it works

We've grouped our network providers into three tiers. You pay the lowest out-of-pocket costs when you use doctors and hospitals in Tier 1 – Preferred.

- You will select a primary care physician (PCP) to coordinate your care and refer you to specialists.
- Your PCP will issue referrals to visit an in-network doctor or other provider (no referrals needed for OB/GYN, mammograms, mental health, or emergency care).
- You can use Tier 1 providers for some covered services and Tiers 2 or 3 for others.
- Services like preventive care, emergency room visits,* and urgent care cost the same across all tiers.

\$	Tier 1 – Preferred
\$\$	Tier 2 – Enhanced
\$\$\$	Tier 3 – Standard

50% of network providers are in Tier 1 – Preferred

Refer to page 77 for a list of in-network hospitals and their tier placements.

This list was current at the time of publication, but tier placement may be updated periodically. To get the latest information, visit ibx.com/providerfinder and select *Keystone HMO Proactive* under Your Plan for the tiers to display.

* If you are admitted to an in-network hospital from the emergency room, the cost-sharing for inpatient hospital care, including medical care provided by an in-network professional provider, will apply based on the tier of the in-network hospital or in-network professional

provider. If you are admitted to an out-of-network hospital following an emergency room admission, the Tier 3 – Standard level of benefits will apply. For non-emergency care, you must use in-network providers.

Other plan benefits

All IBX individual and family health plans include prescription drug coverage. And if you enroll in an HSA-qualified health plan, you have the option to open a health savings account (HSA).



Prescription drug benefits

With an IBX health plan, you get safe, affordable access to covered medications.

Lower-cost options

We're helping members save money on prescriptions.

- **Save with generics.** You'll pay less when your doctor prescribes generic and lower-cost brand alternatives.
- **Pricing transparency.** Your doctor can see how much you'll pay for a medication while they're choosing one to prescribe for you.
- **Better pricing at the pharmacy.** At the pharmacy, you'll automatically pay the most advantageous price available for many non-specialty generic drugs — whether that's available market discounts or your cost-sharing.

Easy-to-use digital tools

Our secure member website makes it easy to manage your prescription drug benefits. Log in to your account on our website or IBX app to find an in-network pharmacy, estimate drug costs, review claims, and submit requests for mail order/home delivery.

Convenient mail order/home delivery

For medications you take regularly, mail order/home delivery is available with free shipping. In most plans, you'll pay less for a 90-day supply when using mail order/home delivery. You can also get a 90-day supply of your maintenance medications at CVS pharmacies for the same cost-sharing as mail order/home delivery.

Savings on self-administered specialty drugs

Our program for self-administered specialty drugs offers convenient delivery options, support, and resources for members who have complex conditions (e.g., cancer, hemophilia, hepatitis C, HIV/AIDS, rheumatoid arthritis, multiple sclerosis, and other inflammatory conditions). Experienced pharmacists and nurses are available by phone or video chat for counseling.

The HSA example is for illustrative purposes only. The HSA example assumes a 22% tax bracket, 3% state taxes, and that the investment choices yield a return of 2%. Please consult with your tax advisor about your situation. Return on investment is not guaranteed.

The Value Formulary has five tiers

\$	Low-cost generic
\$\$	Generic
\$\$\$	Brand-name (Preferred brand)
\$\$\$\$	Brand-name and generic (Non-preferred)
\$\$\$\$\$	Self-administered specialty drug



Maximize your health care dollars with an HSA

If you enroll in an HSA-qualified health plan, you can open a health savings account (HSA). When you use an HSA, your money works harder today and tomorrow:

- You don't pay taxes on money you put into your HSA.*
- You can use HSA funds tax-free to pay for qualified health care expenses (including dental and vision care).
- You can earn tax-free interest or investment income on HSA funds.
- Your savings roll over year-to-year and are yours to keep, even if you change health plans down the road.

For example: Let's say each year you contribute \$2,000 to your HSA and spend \$1,000 on qualified health expenses. Your savings will grow over time, as illustrated below.†

At the end of year 10:

Tax Savings	HSA Balance
\$5,000	\$11,169

* For 2026, contributions to an HSA may not exceed \$4,400 for individual (self only) coverage and \$8,750 for family coverage. The annual "catch-up" contribution amount for ages 55 and older is \$1,000.

† Investment accounts are optional; monthly fees apply. Investment fees are omitted from the example above. The balance in the HSA Investment Account is subject to investment risks, including fluctuations in value and the possible loss of the principal amount invested.

Virtual care: Save time and money

Skip the waiting room, not the care. With virtual care benefits, you can get expert care when and where you need it, making it easier and more affordable to take care of your physical and mental health.

Pay \$0 for virtual care from Teladoc

IBX health plans include virtual care benefits provided by Teladoc Health (Teladoc). You'll pay \$0* for a visit with a Teladoc provider for non-emergency care. Appointments are available by phone, online, or through Teladoc's mobile app for the services listed below. Virtual visits are available in several languages through an interpreter, including American Sign Language (ASL).

You'll pay a \$0* copay for any of the following services provided by Teladoc:



Teladoc General Medical

Talk to a board-certified doctor for non-emergency conditions, such as sinus pain, flu, pink eye, and sore throat. You'll get a diagnosis and prescription (if needed).



Teladoc Health Dermatology

Get convenient and reliable skincare from a licensed dermatologist for a wide range of conditions. Using your Teladoc account, you can request a dermatology consult, complete a short form, and upload images of your skin issue.



Teladoc Mental Health Care

Talk to a licensed psychiatric provider or therapist by phone or video chat. Teladoc's network of behavioral health professionals can help with concerns like anxiety, depression, grief, work pressures, and more, and you can build an ongoing relationship with a provider of your choice if you prefer.

Pay less for in-network virtual care

Many providers in our network offer virtual visits. When you have a virtual visit with your primary care physician or specialist, you'll pay less than you would for an in-office visit. And you'll pay \$0 for virtual behavioral health visits with an in-network behavioral health provider. This reduced cost-sharing is available for virtual visits with in-network providers who offer this option.

NEARLY
90%

of users report being highly satisfied with their Teladoc experience.

MORE THAN
75%

of users with depression or anxiety reported improvement after their third or fourth Teladoc Mental Health Care visit.

* Cost-sharing may apply for Catastrophic and HSA-qualified health plans.

Looking at your options side-by-side

To make it easier to pick the right health plan for you, the next several pages show a side-by-side comparison of our health plans. They are separated by metallic tier and give a quick view of major features of the plans, including:



Network coverage



Deductibles



Out-of-pocket costs for commonly used services



Pharmacy network

Starting on page 17, you can find detailed information about IBX individual and family health plans.



Gold health plans

For more detailed information about Gold health plans, refer to the benefit grids that start on page 19.

Plan name	★ Personal Choice® PPO Gold	Personal Choice® PPO Gold Classic	Personal Choice® PPO Gold Preferred	Keystone HMO Gold	Keystone HMO Gold Proactive	NEW Keystone HMO Gold Proactive Value	Keystone HMO Gold Classic
On/Off exchange	 		 	 	 	 	
PCP and referrals required							
National BlueCard® network							
Out-of-network coverage							
Deductible	\$0	\$1,250	\$0	\$0	\$0	Tier 1 – \$0 Tier 2 – \$4,000 Tier 3 – \$4,000	\$500
Out-of-pocket maximum	\$8,250	\$9,200	\$8,500	\$8,000	\$9,200	\$9,400	\$8,000
Primary care visit — Office/Virtual care	\$30/\$20	20%, no ded/ 20%, no ded	\$15/\$5	\$35/\$25	Tier 1 – \$15/\$10 Tier 2 – \$30/\$20 Tier 3 – \$45/\$30	Tier 1 – \$25/\$15 Tier 2 – \$40/\$25 Tier 3 – \$55/\$35	\$40/\$25
Specialist visit — Office/Virtual care	\$65/\$45	20% after ded/ 20% after ded	\$15/\$5	\$65/\$45	Tier 1 – \$40/\$30 Tier 2 – \$60/\$40 Tier 3 – \$80/\$55	Tier 1 – \$60/\$40 Tier 2 – \$80/\$55 Tier 3 – \$100/\$65	\$80/\$55
Mental health — Outpatient visit	\$65	20% after ded	\$15	\$65	\$40 for each tier	\$60 for each tier	\$80
Urgent care	\$65	20% after ded	\$15	\$65	\$40 for each tier	\$60 for each tier	\$80
Emergency room	\$400	20% after ded	\$325	\$400	\$400 for each tier	\$450 for each tier	\$400
Low-cost generic prescription drugs	\$3	\$3	\$3	\$3	\$3	\$5	\$3
Prescription drug details	Standard Network	Standard Network	Standard Network	Standard Network	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Standard Network

★ Most popular

 This plan can only be purchased through IBX directly and is not available on Pennie.

 This plan is only available for purchase through Pennie.

Note: All health plans include pediatric dental and vision coverage for individuals younger than 19.

Silver health plans

For more detailed information about Silver health plans, refer to the benefit grids that start on page 26.

Plan name	Personal Choice® PPO Silver Classic	Personal Choice® PPO Silver Basic	Keystone HMO Silver Classic	★ Keystone HMO Silver Proactive	Keystone HMO Silver Proactive Lite	Keystone HMO Silver Basic
On/Off exchange	ON	OFF	ON	ON	ON	ON
PCP and referrals required			✓	✓	✓	✓
National BlueCard® network	✓	✓				
Out-of-network coverage	✓	✓				
Deductible	\$3,500	\$4,000	\$3,500	Tier 1 – \$0 Tier 2 – \$6,000 Tier 3 – \$6,000	Tier 1 – \$2,000 Tier 2 – \$6,500 Tier 3 – \$6,500	\$5,500
Out-of-pocket maximum	\$8,250	\$8,500	\$8,500	\$9,200	\$9,200	\$9,000
Primary care visit — Office/Virtual care	\$30/\$20	\$35/\$25	\$35/\$25	Tier 1 – \$40/\$30 Tier 2 – \$70/\$50 Tier 3 – \$80/\$55	Tier 1 – \$50/\$35 Tier 2 – \$60/\$40 Tier 3 – \$70/\$50	\$35/\$25
Specialist visit — Office/Virtual care	\$75/\$50	\$80/\$55	\$80/\$55	Tier 1 – \$90/\$65 Tier 2 – \$140/\$100 Tier 3 – \$150/\$105	Tier 1 – \$90/\$60 Tier 2 – \$120/\$80 Tier 3 – \$140/\$95	\$80/\$55
Mental health — Outpatient visit	\$75	\$80	\$80	\$90 for each tier	\$90 for each tier	\$80
Urgent care	30% after ded	\$80	30% after ded	\$90 for each tier	\$90 for each tier	\$80
Emergency room	30% after ded	\$600	30% after ded	\$950 for each tier	\$950 for each tier	\$600
Low-cost generic prescription drugs	\$3, no ded (integrated with medical ded)	\$3, no ded (integrated with medical ded)	\$3, no ded (integrated with medical ded)	\$7, no ded (\$225 Rx ded for all prescription drugs except generic)	\$5, no ded (\$225 Rx ded for all prescription drugs except generic)	\$3, no ded (integrated with medical ded)
Prescription drug details	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics

★ Most popular

OFF This plan can only be purchased through IBX directly and is not available on Pennie.

ON This plan is only available for purchase through Pennie.

Note: All health plans include pediatric dental and vision coverage for individuals younger than 19.

Silver health plans (continued)

For more detailed information about Silver health plans, refer to the benefit grids that start on page 26.

Plan name	 Keystone HMO Silver Essential	Keystone HMO Silver Proactive Select	 Keystone HMO Silver Proactive Basic	 Keystone HMO Silver Proactive Essential	 Keystone HMO Silver Proactive Value
On/Off exchange					
PCP and referrals required					
National BlueCard® network					
Out-of-network coverage					
Deductible	\$5,000	Tier 1 – \$0 Tier 2 – \$6,000 Tier 3 – \$6,000	Tier 1 – \$2,500 Tier 2 – \$7,000 Tier 3 – \$7,000	Tier 1 – \$5,000 Tier 2 – \$8,000 Tier 3 – \$8,000	Tier 1 – \$1,500 Tier 2 – \$6,000 Tier 3 – \$6,000
Out-of-pocket maximum	\$9,000	\$9,200	\$9,200	\$9,200	\$9,200
Primary care visit — Office/Virtual care	\$45/\$30	Tier 1 – \$40/\$30 Tier 2 – \$70/\$50 Tier 3 – \$80/\$55	Tier 1 – \$50/\$35 Tier 2 – \$60/\$40 Tier 3 – \$70/\$50	Tier 1 – \$50/\$35 Tier 2 – \$60/\$40 Tier 3 – \$70/\$50	Tier 1 – \$40/\$30 Tier 2 – \$60/\$40 Tier 3 – \$70/\$50
Specialist visit — Office/Virtual care	\$75/\$55	Tier 1 – \$90/\$60 Tier 2 – \$140/\$100 Tier 3 – \$150/\$105	Tier 1 – \$100/\$70 Tier 2 – \$120/\$80 Tier 3 – \$140/\$95	Tier 1 – \$100/\$70 Tier 2 – \$120/\$80 Tier 3 – \$140/\$95	Tier 1 – \$80/\$55 Tier 2 – \$120/\$80 Tier 3 – \$140/\$95
Mental health — Outpatient visit	\$75	\$90 for each tier	\$100 for each tier	\$100 for each tier	\$80 for each tier
Urgent care	\$75	\$90 for each tier	\$100 for each tier	\$100 for each tier	\$80 for each tier
Emergency room	\$700	\$950 for each tier	\$950 for each tier	\$975 for each tier	\$950 for each tier
Low-cost generic prescription drugs	\$3, no ded (integrated with medical ded)	\$5, no ded (\$225 Rx ded for all prescription drugs except generic)	\$5, no ded (\$225 Rx ded for all prescription drugs except generic)	\$5, no ded (\$225 Rx ded for all prescription drugs except generic)	\$5, no ded (\$225 Rx ded for all prescription drugs except generic)
Prescription drug details	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics

 Most popular

 This plan can only be purchased through IBX directly and is not available on Pennie.

 This plan is only available for purchase through Pennie.

Note: All health plans include pediatric dental and vision coverage for individuals younger than 19.

Bronze health plans

For more detailed information about Bronze health plans, refer to the benefit grids that start on page 37.

Plan name	Personal Choice® PPO Bronze	Personal Choice® EPO Bronze Reserve + HSA eligible	Personal Choice® EPO Bronze Classic	Personal Choice® EPO Bronze Basic	★ Keystone HMO Bronze	NEW Keystone HMO Bronze Proactive
On/Off exchange	 	 	 	 	 	 
PCP and referrals required						
National BlueCard® network						
Out-of-network coverage						
Deductible	\$6,000	\$7,450	\$4,750	\$9,800	\$8,500	Tier 1 – \$8,000 Tier 2 – \$9,800 Tier 3 – \$9,800
Out-of-pocket maximum	\$9,200	\$7,450	\$9,800	\$9,800	\$9,500	\$10,600
Primary care visit — Office/Virtual care	50%, no ded/ 50%, no ded	0% after ded/ 0% after ded	\$65/\$50	40%, no ded/ 40%, no ded	\$75/\$50	Tier 1 – \$85/\$55 Tier 2 – \$95/\$65 Tier 3 – \$105/\$70
Specialist visit — Office/Virtual care	50% after ded/ 50% after ded	0% after ded/ 0% after ded	\$65/\$50	0% after ded/ 0% after ded	\$150/\$100	Tier 1 – \$170/\$115 Tier 2 – \$180/\$120 Tier 3 – \$190/\$125
Mental health — Outpatient visit	50% after ded	0% after ded	\$65	40%, no ded	\$150	\$150 for all tiers
Urgent care	50% after ded	0% after ded	50% after ded	0% after ded	50% after ded	\$170 for all tiers
Emergency room	50% after ded	0% after ded	50% after ded	0% after ded	50% after ded	\$975 for all tiers
Low-cost generic prescription drugs	\$5, no ded (integrated with medical ded)	0% after ded (integrated with medical ded)	\$5, no ded (integrated with medical ded)	\$5, no ded (integrated with medical ded)	\$5, no ded (integrated with medical ded)	\$7, no ded (\$225 Rx ded for all prescription drugs except generic)
Prescription drug details	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics	Preferred Network, Mandatory Generics

If you are interested in a Catastrophic health plan, see page 43 for more details.

★ Most popular

 This plan can only be purchased through IBX directly and is not available on Pennie.

 This plan is only available for purchase through Pennie.

Note: All health plans include pediatric dental and vision coverage for individuals younger than 19.

Complete your coverage

Our dental and vision plans offer comprehensive benefits to complete your coverage. They are available for adults ages 19 and older and families with children up to age 26. Note: All medical plans include pediatric dental and vision coverage for members younger than 19.



Dental plans

- **Broad provider network.** You have access to one of the largest regional and national dental networks, with more than 500,000 access points.
- **Flexibility to see any dentist.** You'll maximize your savings by using an in-network dentist, but you have the option to see any dentist without a referral.
- **No waiting periods.** You can begin using your benefits immediately for preventive care and certain basic services like fillings and extractions.
- **Preventive rewards program.** The primary subscriber can get \$20 for themselves and each covered dependent who has two cleanings from an in-network dentist during the plan year.
- **Savings incentive for preventive care.** Preventive services don't count against your annual maximum, so you can use that coverage for more expensive services.

See pages 68 – 73 for more details about the dental and vision plans we offer.



Vision plans

- **A network that goes the distance.** The national Davis Vision network has 198,000 access points, including Visionworks, Target Optical, Pearle Vision, Warby Parker, and new this year, LensCrafters.*
- **Fully covered annual eye exam and contact lens fitting.**† You'll pay \$0 for annual routine eye exams and contact lens evaluations and fittings with an in-network provider.
- **\$0 copay and low-cost options for frames and lenses.** Choose from stylish designer frames in the Davis Vision Exclusive Collection. Or use your benefit allowance on non-Collection frames or contact lenses from an in-network provider.
- **Fixed fee pricing on all cosmetic lenses.** Your options include a wide variety of state-of-the-art lens types and styles.
- **Discounts on other services.** Save on other services, such as laser eye correction, hearing exams, and name-brand hearing aid technology from Your Hearing Network.



Plan for the unexpected with LifeSecure

After an accident, serious illness, or hospital stay, your focus should be on your recovery, not your finances. Insurance plans from LifeSecure can help pay for:

- Lost income
- Medical deductibles
- Out-of-network office visits
- Uncovered treatments
- Childcare
- Transportation to appointments
- Household upkeep

Learn more at ibx.com/lifesecond.

* Warby Parker, Target Optical, LensCrafters, and Pearle Vision are out-of-network for pediatric members in ACA medical plans. These providers are in-network for pediatric members when you purchase a stand-alone family vision plan.

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

Vision plans are administered by Davis Vision, an independent company.

Dental plans are underwritten by QCC Insurance 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.

LifeSecure Insurance Company (New Hudson, MI) underwrites and has sole financial responsibility for the Accident, Critical Illness and Hospital Recovery insurance products. The products listed are offered by LifeSecure Insurance Company, an independent company. These are not Blue Cross or Blue Shield products. LifeSecure is solely responsible for the administration of its products. LifeSecure and the logo are trademarks of LifeSecure Insurance Company.

These policies include limitations and exclusions. Refer to the Outline of Coverage or Policy. This is an insurance solicitation. An agent may contact you.

Support for every part of you

Your health and well-being include more than just doctor visits and prescriptions — it's about supporting every part of you. That's why we offer personalized support, programs, and resources to help you feel your best physically, emotionally, and even financially.



24/7 health support from Registered Nurse Health Coaches



Customizable well-being program to help you set and reach health goals



Programs for managing chronic conditions at no additional cost



Money in your pocket for healthy habits



Behavioral health care navigation for personalized guidance and scheduling



Member-exclusive discounts on products and services



Enhanced digital tools for anytime access to your benefits



You're never alone with IBX

For questions about your health plan and benefits, our knowledgeable Customer Service representatives are ready to help. And when you need help or guidance related to your health, we're here for you with specialized support and resources at no additional cost to you.



24/7 health support

Registered Nurse Health Coaches are available 24/7 for health-related questions or to help you manage more serious or complex conditions. Maternity support is also available for expecting members, both during and after pregnancy.



Programs for managing health

Healthy weight management with Wondr

Members can sign up for a personalized digital weight management program from Wondr. Wondr teaches you how to eat your favorite foods, lose weight, sleep better, and gain energy. There's no counting calories, no restrictions, and no guilt.

Chronic condition management

The Teladoc Hypertension and Teladoc Diabetes Management programs make it easier to manage chronic conditions. Eligible members get personalized lessons, free supplies (e.g., unlimited strips for those with diabetes), health alerts, and more.

Complete hearing care

Hearing well is essential to your overall health and well-being. TruHearing provides a comprehensive hearing care solution, including white-glove support, a no-cost hearing exam, and discounts on hearing aids and hardware.



Behavioral health care navigation

Members can call our Behavioral Health Care Navigation team for personalized guidance on finding appropriate behavioral health care.

Our team can:

- Match you with an in-network provider
- Provide in-the-moment support
- Schedule an in-person or virtual appointment for you

A subset of this network, called our Connect to Care network, includes dozens of providers who have committed to getting IBX members into care fast. These providers specialize in general mental health, substance use disorders, OCD, eating disorders, and more for both adults and children.



Scan the QR code or visit ibx.com/bhcare to learn more about behavioral health benefits.

21,000

appointments per
month available
for IBX members

Wondr Health, Teladoc Health, and TruHearing are independent companies.



Customizable well-being program

Achieve Well-being makes it easy and fun to stay motivated on your well-being journey. You can create an action plan and get reminders specific to your health goals. You can also sync up with fitness apps and devices to track your progress, create challenges, and invite friends.



Get rewarded for your healthy habits

Earn up to \$300 in rewards

Here's even more incentive to get healthy. You'll earn up to **\$300** per plan year for completing certain activities, like an annual check-up with your doctor. Redeem your rewards for gift cards for retailers like Amazon, Best Buy, Dunkin', and more.

Get money back on health and fitness

We'll reimburse you **up to \$150** for the cost of each of the following (up to \$450 total):

- Fitness center fees or virtual fitness subscriptions
- Approved weight management programs
- Programs to help you quit using tobacco



Member-exclusive discounts

Discounts on health and fun

Through **Blue365®** and **Blue InsiderSM**, you save on a wide range of health-related products and services, travel, entertainment, and events. Discounts are available for local, regional, and national businesses and retailers, gift certificates, and online shopping. Learn more at ibx.com/discounts.

Lower your out-of-pocket medical costs

AblePay makes it easier to pay for out-of-pocket medical expenses. When you sign up for AblePay and use an AblePay provider, you can **save up to 13%** on out-of-pocket medical costs, including deductibles, copays, and coinsurance. AblePay also offers flexible payment plans for up to 12 months, all with 0% interest. Visit ablepayhealth.com/ibx to learn more.

Save on the cost of college

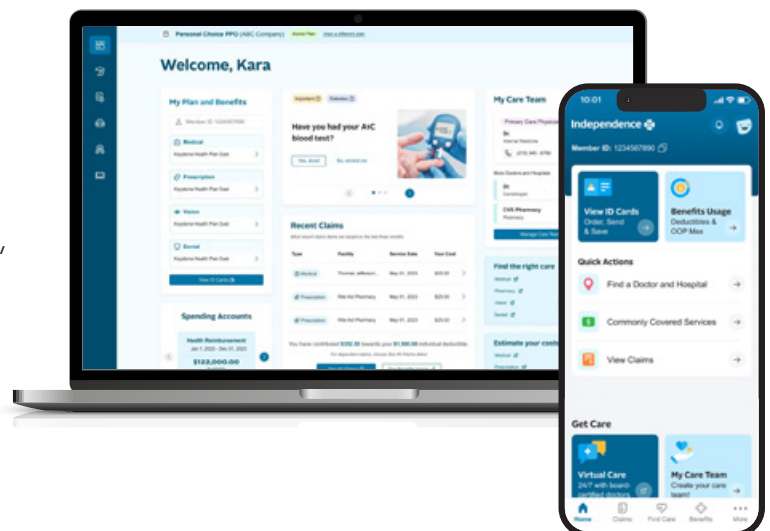
The **College Tuition Benefit** works like a scholarship and can reduce college costs by up to 25%. You earn **SAGE Scholars Tuition Rewards®** Points that are spread evenly over four years of undergraduate education at more than 450 participating colleges and universities. You can sponsor immediate or extended family members. Visit ibx.com/financialwellbeing to learn more.



Enhanced member website and IBX app

Your health journey is unique. We've designed our secure **member website** and **IBX mobile app** to be centered around you, so you can easily manage your benefits and health. Log in anytime and find the information you need, right when you need it. You can:

- View coverage, benefits, and claims
- Estimate out-of-pocket costs
- Create a custom directory of your doctors
- View, share, or order ID cards
- Request or manage home delivery for a prescription
- Pay your bill
- Search for in-network providers and read reviews



These are value-added programs and not a benefit under an Independence Blue Cross health plan and are, therefore, subject to change without notice.

AblePay is an independent company that does not offer Blue Cross or Blue Shield products. Independence Blue Cross is acting solely as an agent for AblePay. AblePay is solely responsible.

The Tuition Rewards program is provided by The College Tuition Benefit, an independent company. Neither The College Tuition Benefit nor SAGE Scholars, Inc. provides Blue Cross or Blue Shield products or services.

2026 Standard Plans



Independence 

IBX

We offer a wide range of standard health plans, so you can choose the one that's best for you. If you qualify for financial assistance, you can enroll in most of these plans using Pennie, the Pennsylvania Insurance Exchange.

Many health plans can be purchased using Pennie or directly through IBX. For plans that are only available on one or the other, please look for the following indicators:



Purchase from IBX directly; not available on Pennie.



Purchase on Pennie; not available through IBX directly.

Gold health plans		Personal Choice® PPO Gold ²	
Benefits per calendar year ¹		You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family		\$0/\$0	\$6,000/\$12,000
Coinsurance		20%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family		\$8,250/\$16,500 copay and coinsurance	\$12,000/\$24,000 ded and coinsurance
Preventive services ⁵			
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 visit — Office/Virtual		\$30/\$20	50% after ded/50% after ded
Specialist visit — Office/Virtual		\$65/\$45	50% after ded/50% after ded
Retail clinic		\$30	50% after ded
Virtual care services from designated virtual provider ²⁵		\$0	Not covered
Urgent care		\$65	50% after ded
Spinal manipulations (20 visits per year) ⁶		\$50	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶		\$65/\$95	50% after ded/50% after ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)		\$750 per day ⁷	50% after ded
Inpatient professional services (includes maternity)		20%	50% after ded
Emergency room (for copay plans, copay waived if admitted)		\$400	\$400, 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 or office/Outpatient		\$120/\$240	50% after ded/50% after ded
Infusion — Home or office/Outpatient		\$65/\$130	50% after ded/50% after ded
Durable medical equipment and prosthetics		50%	50% after ded
Outpatient mental health and substance abuse — Office visit/All other		\$65/\$65	50% after ded/50% after ded
Inpatient mental health and substance abuse		\$750 per day ⁷	50% after ded
Outpatient surgery			
Ambulatory surgical facility/Hospital-based		\$300/\$700	50% after ded/50% after ded
Outpatient lab and pathology			
Freestanding/Hospital-based		\$10/\$85	50% after ded/50% after ded
Prescription drugs ^{12,13}			
Deductible — Individual/Family		None	None
Low-cost generic ¹⁴		\$3	70%
Retail generic ¹⁴		\$20	70%
Retail preferred brand ¹⁴		\$100	70%
Retail non-preferred drug ¹⁴		50%, up to \$200	70%
Self-administered specialty drug		50%, up to \$1,000	Not covered
Additional benefits			
Vision ^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}		\$0	Not covered
Dental ^{21,22}			
Pediatric dental deductible (per individual)		\$50	N/A
Pediatric exams and cleanings ²³		\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	Not covered

Gold health plans			ON Personal Choice® PPO Gold Classic ²		
Benefits per calendar year ¹			You pay in-network		You pay out-of-network ⁴
Deductible — Individual/Family			\$1,250/\$2,500		\$6,000/\$12,000
Coinsurance			20%, unless otherwise noted		50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family			\$9,200/\$18,400 copay, ded, and coinsurance		\$25,000/\$50,000 ded and coinsurance
Preventive services ⁵					
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 visit — Office/Virtual			20%, no ded/20%, no ded		50% after ded/50% after ded
Specialist visit — Office/Virtual			20% after ded/20% after ded		50% after ded/50% after ded
Retail clinic			20%, no ded		50% after ded
Virtual care services from designated virtual provider ²⁵			0%, no ded		Not covered
Urgent care			20% after ded		50% after ded
Spinal manipulations (20 visits per year) ⁶			20% after ded		50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶			20% after ded/20% after ded		50% after ded/50% after ded
Hospital and other medical services					
Inpatient hospital services (includes maternity)			20% after ded		50% after ded
Inpatient professional services (includes maternity)			20% after ded		50% after ded
Emergency room (for copay plans, copay waived if admitted)			20% after ded		20% after in-network ded
Routine radiology/diagnostic — Freestanding/Hospital-based			20% after ded/20% after ded		50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based			20% after ded/20% after ded		50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient			20% after ded/40% after ded		50% after ded/50% after ded
Infusion — Home or office/Outpatient			20% after ded/40% after ded		50% after ded/50% after ded
Durable medical equipment and prosthetics			50% after ded		50% after ded
Outpatient mental health and substance abuse — Office visit/All other			20% after ded/20% after ded		50% after ded/50% after ded
Inpatient mental health and substance abuse			20% after ded		50% after ded
Outpatient surgery					
Ambulatory surgical facility/Hospital-based			20% after ded/40% after ded		50% after ded/50% after ded
Outpatient lab and pathology					
Freestanding/Hospital-based			20% after ded/50% after ded		50% after ded/50% after ded
Prescription drugs ^{12,13}					
Deductible — Individual/Family			None		None
Low-cost generic ¹⁴			\$3		70%
Retail generic ¹⁴			\$20		70%
Retail preferred brand ¹⁴			\$100		70%
Retail non-preferred drug ¹⁴			50%, up to \$200		70%
Self-administered specialty drug			50%, up to \$1,000		Not covered
Additional benefits					
Vision ^{17,18}					
Pediatric exam and pediatric eyewear ^{19,20}			\$0, no ded		Not covered
Dental ^{21,22}					
Pediatric dental deductible (per individual)			\$50		N/A
Pediatric exams and cleanings ²³			\$0, no ded		Not covered
Pediatric basic, major, and orthodontia services ^{24,29}			50% after ded		Not covered

Gold health plans		Personal Choice® PPO Gold Preferred ²	
Benefits per calendar year ¹		You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family		\$0/\$0	\$6,000/\$12,000
Coinsurance		20%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family		\$8,500/\$17,000 copay and coinsurance	\$12,000/\$24,000 ded and coinsurance
Preventive services ⁵			
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 visit — Office/Virtual		\$15/\$5	50% after ded/50% after ded
Specialist visit — Office/Virtual		\$15/\$5	50% after ded/50% after ded
Retail clinic		\$15	50% after ded
Virtual care services from designated virtual provider ²⁵		\$0	Not covered
Urgent care		\$15	50% after ded
Spinal manipulations (20 visits per year) ⁶		\$50	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶		\$45/\$45	50% after ded/50% after ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)		\$500 per day ⁷	50% after ded
Inpatient professional services (includes maternity)		20%	50% after ded
Emergency room (for copay plans, copay waived if admitted)		\$325	\$325, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based		\$105/\$105	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$300/\$300	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient		\$120/\$240	50% after ded/50% after ded
Infusion — Home or office/Outpatient		\$45/\$90	50% after ded/50% after ded
Durable medical equipment and prosthetics		50%	50% after ded
Outpatient mental health and substance abuse — Office visit/All other		\$15/\$45	50% after ded/50% after ded
Inpatient mental health and substance abuse		\$500 per day ⁷	50% after ded
Outpatient surgery			
Ambulatory surgical facility/Hospital-based		\$300/\$700	50% after ded/50% after ded
Outpatient lab and pathology			
Freestanding/Hospital-based		\$10/\$85	50% after ded/50% after ded
Prescription drugs ^{12,13}			
Deductible — Individual/Family		None	None
Low-cost generic ¹⁴		\$3	70%
Retail generic ¹⁴		\$20	70%
Retail preferred brand ¹⁴		\$100	70%
Retail non-preferred drug ¹⁴		50%, up to \$200	70%
Self-administered specialty drug		50%, up to \$1,000	Not covered
Additional benefits			
Vision ^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}		\$0	Not covered
Dental ^{21,22}			
Pediatric dental deductible (per individual)		\$50	N/A
Pediatric exams and cleanings ²³		\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	Not covered

Gold health plans	Keystone HMO Gold ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$0/\$0
Coinsurance	20%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$8,000/\$16,000 copay and coinsurance
Preventive services⁵	
Preventive care for adults and children	\$0
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	\$0
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750
Physician services	
Primary care visit — Office/Virtual	\$35/\$25
Specialist visit — Office/Virtual	\$65/\$45
Retail clinic	\$35
Virtual care services from designated virtual provider ²⁵	\$0
Urgent care	\$65
Spinal manipulations (20 visits per year)	\$50
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$65/\$65
Hospital and other medical services	
Inpatient hospital services (includes maternity)	\$750 per day ⁷
Inpatient professional services (includes maternity)	20%
Emergency room (for copay plans, copay waived if admitted)	\$400
Routine radiology/diagnostic — Freestanding/Hospital-based	\$60/\$60
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$120/\$120
Biotech/Specialty injectables — Home or office/Outpatient	\$120/\$240
Infusion — Home or office/Outpatient	\$65/\$130
Durable medical equipment and prosthetics	50%
Outpatient mental health and substance abuse — Office visit/All other	\$65/\$65
Inpatient mental health and substance abuse	\$750 per day ⁷
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$300/\$700
Outpatient lab and pathology	
Freestanding/Hospital-based	\$10/\$10
Prescription drugs^{12,13}	
Deductible — Individual/Family	None
Low-cost generic ¹⁴	\$3
Retail generic ¹⁴	\$20
Retail preferred brand ¹⁴	\$100
Retail non-preferred drug ¹⁴	50%, up to \$200
Self-administered specialty drug	50%, up to \$1,000
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Gold health plans		Keystone HMO Gold Proactive ²		
Benefits per calendar year ¹		You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family		\$0/\$0	\$0/\$0	\$0/\$0
Coinsurance		0%, unless otherwise noted	20%, unless otherwise noted	30%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹		\$9,200/\$18,400 copay and coinsurance	\$9,200/\$18,400 copay and coinsurance	\$9,200/\$18,400 copay and coinsurance
Preventive services ⁵				
Preventive care for adults and children		\$0	\$0	\$0
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers		\$0	\$0	\$0
Preventive colonoscopy for colorectal cancer screening — Hospital-based		\$750	\$750	\$750
Physician services				
Primary care visit — Office/Virtual		\$15/\$10	\$30/\$20	\$45/\$30
Specialist visit — Office/Virtual		\$40/\$30	\$60/\$40	\$80/\$55
Retail clinic ¹¹		\$15	\$30	\$45
Virtual care services from designated virtual provider ²⁵		\$0	\$0	\$0
Urgent care		\$40	\$40	\$40
Spinal manipulations (20 visits per year)		\$50	\$50	\$50
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$60/\$60	\$60/\$60	\$60/\$60
Hospital and other medical services				
Inpatient hospital services (includes maternity)		\$350 per day ⁷	\$700 per day ⁷	\$1,100 per day ⁷
Inpatient professional services (includes maternity)		0%	20%	30%
Emergency room (for copay plans, copay waived if admitted) ¹⁰		\$400	\$400	\$400
Routine radiology/diagnostic — Freestanding/Hospital-based		\$60/\$60	\$60/\$60	\$60/\$60
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$120/\$120	\$120/\$120	\$120/\$120
Biotech/Specialty injectables — Home or office/Outpatient		50%/50%	50%/50%	50%/50%
Infusion — Home or office/Outpatient		0%/0%	20%/20%	30%/30%
Durable medical equipment and prosthetics		50%	50%	50%
Outpatient mental health and substance abuse — Office visit/All other		\$40/\$40	\$40/\$40	\$40/\$40
Inpatient mental health and substance abuse		\$350 per day ⁷	\$350 per day ⁷	\$350 per day ⁷
Outpatient surgery				
Ambulatory surgical facility/Hospital-based		\$150/\$150	\$550/\$550	\$1,000/\$1,000
Outpatient lab and pathology				
Freestanding/Hospital-based		\$10/\$10	\$10/\$10	\$10/\$10
Prescription drugs ^{12,13,15}				
Deductible — Individual/Family		None	None	None
Low-cost generic ¹⁴		\$3	\$3	\$3
Retail generic ¹⁴		\$20	\$20	\$20
Retail preferred brand ^{14,16}		\$100	\$100	\$100
Retail non-preferred drug ^{14,16}		50%, up to \$300	50%, up to \$300	50%, up to \$300
Self-administered specialty drug ¹⁶		50%, up to \$1,000	50%, up to \$1,000	50%, up to \$1,000
Additional benefits				
Vision ^{17,18}				
Pediatric exam and pediatric eyewear ^{19,20}		\$0	\$0	\$0
Dental ^{21,22}				
Pediatric dental deductible (per individual)		\$50	\$50	\$50
Pediatric exams and cleanings ²³		\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	50% after ded	50% after ded

Gold health plans		Keystone HMO Gold Proactive Value ² NEW		
Benefits per calendar year ¹		You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸		\$0/\$0	\$4,000/\$8,000	\$4,000/\$8,000
Coinsurance		0%, unless otherwise noted	20%, unless otherwise noted	30%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹		\$9,400/\$18,800 copay, ded, and coinsurance	\$9,400/\$18,800 copay, ded, and coinsurance	\$9,400/\$18,800 copay, ded, and coinsurance
Preventive services ⁵				
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 visit — Office/Virtual		\$25/\$15	\$40, no ded/\$25, no ded	\$55, no ded/\$35, no ded
Specialist visit — Office/Virtual		\$60/\$40	\$80, no ded/\$55, no ded	\$100, no ded/\$65, no ded
Retail clinic ¹¹		\$25	\$40, no ded	\$55, no ded
Virtual care services from designated virtual provider ²⁵		0%	0%, no ded	0%, no ded
Urgent care		\$60	\$60, no ded	\$60, no ded
Spinal manipulations (20 visits per year)		\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$60/\$60	\$60, no ded/\$60, no ded	\$60, no ded/\$60, no ded
Hospital and other medical services				
Inpatient hospital services (includes maternity)		\$350 per day ⁷	Subject to ded and \$700 copay per day ⁷	Subject to ded and \$1,100 copay per day ⁷
Inpatient professional services (includes maternity)		0%	20% after ded	30% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰		\$450	\$450, no ded	\$450, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based		\$100/\$100	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$150/\$150	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Biotech/Specialty injectables — Home or office/Outpatient		50%/50%	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient		0%/0%	20% after ded/20% after ded	30% after ded/30% after ded
Durable medical equipment and prosthetics		50%	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other		\$60/\$60	\$60, no ded/\$60, no ded	\$60, no ded/\$60, no ded
Inpatient mental health and substance abuse		\$350 per day ⁷	\$350 per day, no ded ⁷	\$350 per day, no ded ⁷
Outpatient surgery				
Ambulatory surgical facility/Hospital-based		\$150/\$150	Subject to ded and \$550 copay/ Subject to ded and \$550 copay	Subject to ded and \$1,000 copay/ Subject to ded and \$1,000 copay
Outpatient lab and pathology				
Freestanding/Hospital-based		\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs ^{12,13,15}				
Deductible — Individual/Family		None	None	None
Low-cost generic ¹⁴		\$5	\$5	\$5
Retail generic ¹⁴		\$25	\$25	\$25
Retail preferred brand ^{14,16}		50%	50%	50%
Retail non-preferred drug ^{14,16}		50%	50%	50%
Self-administered specialty drug ¹⁶		50%	50%	50%
Additional benefits				
Vision ^{17,18}				
Pediatric exam and pediatric eyewear ^{19,20}		\$0	\$0, no ded	\$0, no ded
Dental ^{21,22}				
Pediatric dental deductible (per individual)		\$50	\$50	\$50
Pediatric exams and cleanings ²³		\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	50% after ded	50% after ded

Gold health plans

Keystone HMO Gold Classic²Benefits per calendar year¹

Deductible — Individual/Family

Coinsurance

Out-of-pocket maximum — Individual/Family

Preventive services⁵

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 visit — Office/Virtual

Specialist visit — Office/Virtual

Retail clinic

Virtual care services from designated virtual provider²⁵

Urgent care

Spinal manipulations (20 visits per year)

Physical/Occupational therapy (30 visits per year) —
Freestanding/Hospital-based

Hospital and other medical services

Inpatient hospital services (includes maternity)

Inpatient professional services (includes maternity)

Emergency room (for copay plans, copay waived if admitted)

Routine radiology/diagnostic — Freestanding/Hospital-based

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

Biotech/Specialty injectables — Home or office/Outpatient

Infusion — Home or office/Outpatient

Durable medical equipment and prosthetics

Outpatient mental health and substance abuse — Office visit/All other

Inpatient mental health and substance abuse

Outpatient surgery

Ambulatory surgical facility/Hospital-based

Outpatient lab and pathology

Freestanding/Hospital-based

Prescription drugs^{12,13}

Deductible — Individual/Family

Low-cost generic¹⁴Retail generic¹⁴Retail preferred brand¹⁴Retail non-preferred drug¹⁴

Self-administered specialty drug

Additional benefits

Vision^{17,18}Pediatric exam and pediatric eyewear^{19,20}Dental^{21,22}

Pediatric dental deductible (per individual)

Pediatric exams and cleanings²³Pediatric basic, major, and orthodontia services^{24,29}You pay in-network³

\$500/\$1,000

20%, unless otherwise noted

\$8,000/\$16,000 copay, ded, and coinsurance

\$0, no ded

\$0, no ded

\$750, no ded

\$40, no ded/\$25, no ded

\$80, no ded/\$55, no ded

\$40, no ded

\$0, no ded

\$80, no ded

\$50, no ded

\$80, no ded/\$80, no ded

20% after ded

20% after ded

\$400, no ded

\$60, no ded/\$60, no ded

\$125, no ded/\$125, no ded

\$150, no ded/\$300, no ded

\$80, no ded/\$160, no ded

50% after ded

\$80, no ded/\$80, no ded

20% after ded

\$300, no ded/\$700, no ded

\$10, no ded/\$10, no ded

None

\$3

\$20

\$100

50%, up to \$200

50%, up to \$1,000

\$0, no ded

\$50

\$0, no ded

50% after ded

Silver health plans		ON Personal Choice® PPO Silver Classic ²
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family	\$3,500/\$7,000	\$10,000/\$20,000
Coinsurance	30%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$8,250/\$16,500 copay, ded, and coinsurance	\$20,000/\$40,000 ded and coinsurance
Preventive services ⁵		
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 visit — Office/Virtual	\$30, no ded/\$20, no ded	50% after ded/50% after ded
Specialist visit — Office/Virtual	\$75, no ded/\$50, no ded	50% after ded/50% after ded
Retail clinic	\$30, no ded	50% after ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	Not covered
Urgent care	30% after ded	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$50, no ded	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶	\$75, no ded/\$105, no ded	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	25% after ded	50% after ded
Inpatient professional services (includes maternity)	30% after ded	50% after ded
Emergency room (for copay plans, copay waived if admitted)	30% after ded	30% after in-network ded
Routine radiology/diagnostic — Freestanding/Hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Infusion — Home or office/Outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment and prosthetics	50% after ded	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$75, no ded/30% after ded	50% after ded/50% after ded
Inpatient mental health and substance abuse	25% after ded	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	20%, no ded/50%, no ded	50% after ded/50% after ded
Prescription drugs ^{12,13,15}		
Deductible — Individual/Family	Integrated with medical ded	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded	70%, no ded
Retail generic ¹⁴	\$20, no ded	70%, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$300	70% after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400	70% after ded
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	Not covered
Additional benefits		
Vision ^{17,18}		
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	Not covered
Dental ^{21,22}		
Pediatric dental deductible (per individual)	\$50	N/A
Pediatric exams and cleanings ²³	\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	Not covered

Silver health plans		OFF Personal Choice® PPO Silver Basic ²
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family	\$4,000/\$8,000	\$10,000/\$20,000
Coinsurance	30% unless otherwise noted	50% unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$8,500/\$17,000 copay, ded, and coinsurance	\$20,000/\$40,000 ded and coinsurance
Preventive services ⁵		
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 visit — Office/Virtual	\$35, no ded/\$25, no ded	50% after ded/50% after ded
Specialist visit — Office/Virtual	\$80, no ded/\$55, no ded	50% after ded/50% after ded
Retail clinic	\$35, no ded	50% after ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	Not covered
Urgent care	\$80, no ded	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$50, no ded	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶	\$80, no ded/\$110, no ded	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	25% after ded	50% after ded
Inpatient professional services (includes maternity)	30% after ded	50% after ded
Emergency room (for copay plans, copay waived if admitted)	\$600, no ded	\$600, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$100, no ded/\$150, no ded	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$200, no ded/\$250, no ded	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Infusion — Home or office/Outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment and prosthetics	50% after ded	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$80, no ded/\$80, no ded	50% after ded/50% after ded
Inpatient mental health and substance abuse	25% after ded	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	\$750 after ded/\$750 after ded	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	\$15, no ded/\$85, no ded	50% after ded/50% after ded
Prescription drugs ^{12,13,15}		
Deductible — Individual/Family	Integrated with medical ded	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded	70%, no ded
Retail generic ¹⁴	\$20, no ded	70%, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$300	70% after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400	70% after ded
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	Not covered
Additional benefits		
Vision ^{17,18}		
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	Not covered
Dental ^{21,22}		
Pediatric dental deductible (per individual)	\$50	N/A
Pediatric exams and cleanings ²³	\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	Not covered

Silver health plans		ON Keystone HMO Silver Classic ²	
Benefits per calendar year¹		You pay in-network³	
Deductible — Individual/Family		\$3,500/\$7,000	
Coinsurance		30% unless otherwise noted	
Out-of-pocket maximum — Individual/Family		\$8,500/\$17,000 copay, ded, and coinsurance	
Preventive services⁵			
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 visit — Office/Virtual		\$35, no ded/\$25, no ded	
Specialist visit — Office/Virtual		\$80, no ded/\$55, no ded	
Retail clinic		\$35, no ded	
Virtual care services from designated virtual provider ²⁵		0%, no ded	
Urgent care		30% after ded	
Spinal manipulations (20 visits per year)		\$50, no ded	
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$80, no ded/\$80, no ded	
Hospital and other medical services			
Inpatient hospital services (includes maternity)		30% after ded	
Inpatient professional services (includes maternity)		30% after ded	
Emergency room (for copay plans, copay waived if admitted)		30% after ded	
Routine radiology/diagnostic — Freestanding/Hospital-based		\$120, no ded/\$120, no ded	
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$250, no ded/\$250, no ded	
Biotech/Specialty injectables — Home or office/Outpatient		30% after ded/50% after ded	
Infusion — Home or office/Outpatient		30% after ded/50% after ded	
Durable medical equipment and prosthetics		50% after ded	
Outpatient mental health and substance abuse — Office visit/All other		\$80, no ded/\$80, no ded	
Inpatient mental health and substance abuse		30% after ded	
Outpatient surgery			
Ambulatory surgical facility/Hospital-based		\$400, no ded/\$800, no ded	
Outpatient lab and pathology			
Freestanding/Hospital-based		\$15, no ded/\$15, no ded	
Prescription drugs^{12,13,15}			
Deductible — Individual/Family		Integrated with medical ded	
Low-cost generic ¹⁴		\$3, no ded	
Retail generic ¹⁴		\$20, no ded	
Retail preferred brand ^{14,16}		50% after ded, up to \$300	
Retail non-preferred drug ^{14,16}		50% after ded, up to \$400	
Self-administered specialty drug ¹⁶		50% after ded, up to \$1,000	
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}		\$0, no ded	
Dental^{21,22}			
Pediatric dental deductible (per individual)		\$50	
Pediatric exams and cleanings ²³		\$0, no ded	
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	

Silver health plans		ON Keystone HMO Silver Proactive ²	
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$9,200/\$18,400 copay and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$40/\$30	\$70, no ded/\$50, no ded	\$80, no ded/\$55, no ded
Specialist visit — Office/Virtual	\$90/\$65	\$140, no ded/\$100, no ded	\$150, no ded/\$105, no ded
Retail clinic ¹¹	\$40	\$70, no ded	\$80, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$90	\$90, no ded	\$90, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$950	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150/\$150	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$375/\$375	\$375, no ded/\$375, no ded	\$375, no ded/\$375, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%/50%	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Inpatient mental health and substance abuse	\$600 per day ⁷	\$600 per day, no ded ⁷	\$600 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$250/\$250	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$7, no ded	\$7, no ded	\$7, no ded
Retail generic ¹⁴	\$25, no ded	\$25, no ded	\$25, no ded
Retail preferred brand ^{14,16}	\$100 after ded	\$100 after ded	\$100 after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver health plans		ON Keystone HMO Silver Proactive Lite ²	
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$2,000/\$4,000	\$6,500/\$13,000	\$6,500/\$13,000
Coinsurance	0% unless otherwise noted	5% unless otherwise noted	10% unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services ⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$90, no ded/\$60, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$90, no ded	\$90, no ded	\$90, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$950, no ded	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs ^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}	\$90 after ded	\$90 after ded	\$90 after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision ^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental ^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver health plans		ON Keystone HMO Silver Basic ²	
Benefits per calendar year¹		You pay in-network³	
Deductible — Individual/Family		\$5,500/\$11,000	
Coinsurance		50% unless otherwise noted	
Out-of-pocket maximum — Individual/Family		\$9,000/\$18,000 copay, ded, and coinsurance	
Preventive services⁵			
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 visit — Office/Virtual		\$35, no ded/\$25, no ded	
Specialist visit — Office/Virtual		\$80, no ded/\$55, no ded	
Retail clinic		\$35, no ded	
Virtual care services from designated virtual provider ²⁵		0%, no ded	
Urgent care		\$80, no ded	
Spinal manipulations (20 visits per year)		\$50, no ded	
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$80, no ded/\$80, no ded	
Hospital and other medical services			
Inpatient hospital services (includes maternity)		50% after ded	
Inpatient professional services (includes maternity)		50% after ded	
Emergency room (for copay plans, copay waived if admitted)		\$600, no ded	
Routine radiology/diagnostic — Freestanding/Hospital-based		\$175, no ded/\$175, no ded	
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$350, no ded/\$350, no ded	
Biotech/Specialty injectables — Home or office/Outpatient		50% after ded/50% after ded	
Infusion — Home or office/Outpatient		50% after ded/50% after ded	
Durable medical equipment and prosthetics		50% after ded	
Outpatient mental health and substance abuse — Office visit/All other		\$80, no ded/\$120, no ded	
Inpatient mental health and substance abuse		50% after ded	
Outpatient surgery			
Ambulatory surgical facility/Hospital-based		\$1,650 after ded/\$1,650 after ded	
Outpatient lab and pathology			
Freestanding/Hospital-based		\$15, no ded/\$15, no ded	
Prescription drugs^{12,13,15}			
Deductible — Individual/Family		Integrated with medical ded	
Low-cost generic ¹⁴		\$3, no ded	
Retail generic ¹⁴		\$20, no ded	
Retail preferred brand ^{14,16}		50% after ded, up to \$300	
Retail non-preferred drug ^{14,16}		50% after ded, up to \$400	
Self-administered specialty drug ¹⁶		50% after ded, up to \$1,000	
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}		\$0, no ded	
Dental^{21,22}			
Pediatric dental deductible (per individual)		\$50	
Pediatric exams and cleanings ²³		\$0, no ded	
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	

Silver health plans



Keystone HMO Silver Essential² **NEW**

Benefits per calendar year¹

Deductible — Individual/Family
Coinsurance
Out-of-pocket maximum — Individual/Family

You pay in-network³

\$5,000/\$10,000
50% unless otherwise noted
\$9,000/\$18,000 copay, ded, and coinsurance

Preventive services⁵

Preventive care for adults and children
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers
Preventive colonoscopy for colorectal cancer screening — Hospital-based

0%, no ded
0%, no ded
\$750, no ded

Physician services

Primary care visit — Office/Virtual
Specialist visit — Office/Virtual
Retail clinic
Virtual care services from designated virtual provider ²⁵
Urgent care
Spinal manipulations (20 visits per year)
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based

\$45, no ded/\$30, no ded
\$75, no ded/\$55, no ded
\$45, no ded
0%, no ded
\$75, no ded
\$50, no ded
\$75, no ded/\$75, no ded

Hospital and other medical services

Inpatient hospital services (includes maternity)
Inpatient professional services (includes maternity)
Emergency room (for copay plans, copay waived if admitted)
Routine radiology/diagnostic — Freestanding/Hospital-based
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based
Biotech/Specialty injectables — Home or office/Outpatient
Infusion — Home or office/Outpatient
Durable medical equipment and prosthetics
Outpatient mental health and substance abuse — Office visit/All other
Inpatient mental health and substance abuse

50% after ded
50% after ded
\$700, no ded
\$150, no ded/\$150, no ded
\$300, no ded/\$300, no ded
50% after ded/50% after ded
50% after ded/50% after ded
50% after ded
\$75, no ded/\$120, no ded
50% after ded

Outpatient surgery

Ambulatory surgical facility/Hospital-based

\$500 after ded/\$1,000 after ded

Outpatient lab and pathology

Freestanding/Hospital-based

\$15, no ded/\$15, no ded

Prescription drugs^{12,13,15}

Deductible — Individual/Family
Low-cost generic ¹⁴
Retail generic ¹⁴
Retail preferred brand ^{14,16}
Retail non-preferred drug ^{14,16}
Self-administered specialty drug ¹⁶

Integrated with medical ded
\$3, no ded
\$20, no ded
50% after ded, up to \$300
50% after ded, up to \$400
50% after ded, up to \$1,000

Additional benefits

Vision ^{17,18}
Pediatric exam and pediatric eyewear ^{19,20}
Dental ^{21,22}
Pediatric dental deductible (per individual)
Pediatric exams and cleanings ²³
Pediatric basic, major, and orthodontia services ^{24,29}

\$0, no ded
\$50
\$0, no ded
50% after ded

Silver health plans

Keystone HMO Silver Proactive Select²

Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$9,200/\$18,400 copay and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$40/\$30	\$70, no ded/\$50, no ded	\$80, no ded/\$55, no ded
Specialist visit — Office/Virtual	\$90/\$60	\$140, no ded/\$100, no ded	\$150, no ded/\$105, no ded
Retail clinic ¹¹	\$40	\$70, no ded	\$80, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$90	\$90, no ded	\$90, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$950	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150/\$150	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$375/\$375	\$375, no ded/\$375, no ded	\$375, no ded/\$375, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%/50%	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Inpatient mental health and substance abuse	\$600 per day ⁷	\$600 per day, no ded ⁷	\$600 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$250/\$250	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$25, no ded	\$25, no ded	\$25, no ded
Retail preferred brand ^{14,16}	\$100 after ded	\$100 after ded	\$100 after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver health plans		ON Keystone HMO Silver Proactive Basic ²	
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$2,500/\$5,000	\$7,000/\$14,000	\$7,000/\$14,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$100, no ded/\$70, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$100, no ded	\$100, no ded	\$100, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$950, no ded	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$400	50% after ded, up to \$400	50% after ded, up to \$400
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver health plans

Keystone HMO Silver Proactive Essential²

Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$5,000/\$10,000	\$8,000/\$16,000	\$8,000/\$16,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$100, no ded/\$70, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$100, no ded	\$100, no ded	\$100, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$975, no ded	\$975, no ded	\$975, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$25, no ded	\$25, no ded	\$25, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$400	50% after ded, up to \$400	50% after ded, up to \$400
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver health plans		OFF Keystone HMO Silver Proactive Value²	
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$1,500/\$3,000	\$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 ⁹	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance	\$9,200/\$18,400 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$40, no ded/\$30, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$80, no ded/\$55, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$40, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$80, no ded	\$80, no ded	\$80, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$80, no ded/\$80, no ded	\$80, no ded/\$80, no ded	\$80, no ded/\$80, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$950, no ded	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$80, no ded/\$80, no ded	\$80, no ded/\$80, no ded	\$80, no ded/\$80, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}	\$100 after ded	\$100 after ded	\$100 after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Bronze health plans		Personal Choice [®] PPO Bronze ²	
Benefits per calendar year ¹		You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family		\$6,000/\$12,000	\$15,000/\$30,000
Coinsurance		50%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family		\$9,200/\$18,400 copay, ded, and coinsurance	\$25,000/\$50,000 ded and coinsurance
Preventive services ⁵			
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 visit — Office/Virtual		50%, no ded/50%, no ded	50% after ded/50% after ded
Specialist visit — Office/Virtual		50% after ded/50% after ded	50% after ded/50% after ded
Retail clinic		50%, no ded	50% after ded
Virtual care services from designated virtual provider ²⁵		0%, no ded	Not covered
Urgent care		50% after ded	50% after ded
Spinal manipulations (20 visits per year) ⁶		50% after ded	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶		50% after ded/50% after ded	50% after ded/50% after ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)		25% after ded	50% after ded
Inpatient professional services (includes maternity)		50% after ded	50% after ded
Emergency room (for copay plans, copay 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 or office/Outpatient		50% after ded/50% after ded	50% after ded/50% after ded
Infusion — Home or office/Outpatient		50% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment and prosthetics		50% after ded	50% after ded
Outpatient mental health and substance abuse — Office visit/All other		50% after ded/50% after ded	50% after ded/50% after ded
Inpatient mental health and substance abuse		25% after ded	50% after ded
Outpatient surgery			
Ambulatory surgical facility/Hospital-based		50% after ded/50% after ded	50% after ded/50% after ded
Outpatient lab and pathology			
Freestanding/Hospital-based		20% after ded/50% after ded	50% after ded/50% after ded
Prescription drugs ^{12,13,15}			
Deductible — Individual/Family		Integrated with medical ded	Integrated with medical ded
Low-cost generic ¹⁴		\$5, no ded	70%, no ded
Retail generic ¹⁴		\$35, no ded	70%, no ded
Retail preferred brand ^{14,16}		50% after ded	70% after ded
Retail non-preferred drug ^{14,16}		50% after ded	70% after ded
Self-administered specialty drug ¹⁶		50% after ded	Not covered
Additional benefits			
Vision ^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}		\$0, no ded	Not covered
Dental ^{21,22}			
Pediatric dental deductible (per individual)		\$50	N/A
Pediatric exams and cleanings ²³		\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	Not covered

Bronze health plans	Personal Choice [®] EPO Bronze Reserve + HSA eligible ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$7,450/\$14,900
Coinsurance	0%
Out-of-pocket maximum — Individual/Family	\$7,450/\$14,900 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	0% after ded/0% after ded
Specialist visit — Office/Virtual	0% after ded/0% after ded
Retail clinic	0% after ded
Virtual care services from designated virtual provider ²⁵	0% after ded
Urgent care	0% after ded
Spinal manipulations (20 visits per year)	0% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	0% after ded/0% after ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	0% after ded
Inpatient professional services (includes maternity)	0% after ded
Emergency room (for copay plans, copay 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 or office/Outpatient	0% after ded/0% after ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded
Durable medical equipment and prosthetics	0% after ded
Outpatient mental health and substance abuse — Office visit/All other	0% after ded/0% after ded
Inpatient mental health and substance abuse	0% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	0% after ded/0% after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	0% after ded/0% after ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	0% after ded
Retail generic ¹⁴	0% after ded
Retail preferred brand ^{14,16}	0% after ded
Retail non-preferred drug ^{14,16}	0% after ded
Self-administered specialty drug ¹⁶	0% after ded
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	Integrated with medical ded
Pediatric exams and cleanings ²³	0%, no ded
Pediatric basic, major, and orthodontia services ²⁴	0% after ded

Bronze health plans	Personal Choice® EPO Bronze Classic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$4,750/\$9,500
Coinsurance	50%
Out-of-pocket maximum — Individual/Family	\$9,800/\$19,600 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$65, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$65, no ded/\$50, no ded
Retail clinic	\$65, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	50% after ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$65, no ded/\$65, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	50% after ded
Inpatient professional services (includes maternity)	50% after ded
Emergency room (for copay plans, copay waived if admitted)	50% after ded
Routine radiology/diagnostic — Freestanding/Hospital-based	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	50% after ded/50% after ded
Infusion — Home or office/Outpatient	50% after ded/50% after ded
Durable medical equipment and prosthetics	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$65, no ded/50% after ded
Inpatient mental health and substance abuse	50% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	50% after ded/50% after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	50% after ded/50% after ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$5, no ded
Retail generic ¹⁴	50% after ded
Retail preferred brand ^{14,16}	50% after ded
Retail non-preferred drug ^{14,16}	50% after ded
Self-administered specialty drug ¹⁶	50% after ded
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Bronze health plans	Personal Choice® EPO Bronze Basic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$9,800/\$19,600
Coinsurance	0%
Out-of-pocket maximum — Individual/Family	\$9,800/\$19,600 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	40%, no ded/40%, no ded
Specialist visit — Office/Virtual	0% after ded/0% after ded
Retail clinic	0% after ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	0% after ded
Spinal manipulations (20 visits per year)	0% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	0% after ded/0% after ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	0% after ded
Inpatient professional services (includes maternity)	0% after ded
Emergency room (for copay plans, copay 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 or office/Outpatient	0% after ded/0% after ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded
Durable medical equipment and prosthetics	0% after ded
Outpatient mental health and substance abuse — Office visit/All other	40%, no ded/0% after ded
Inpatient mental health and substance abuse	0% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	0% after ded/0% after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	0% after ded/0% after ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$5, no ded
Retail generic ¹⁴	\$25, no ded
Retail preferred brand ^{14,16}	0% after ded
Retail non-preferred drug ^{14,16}	0% after ded
Self-administered specialty drug ¹⁶	0% after ded
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	Integrated with medical ded
Pediatric exams and cleanings ²³	0%, no ded
Pediatric basic, major, and orthodontia services ²⁴	0% after ded

Bronze health plans	Keystone HMO Bronze ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$8,500/\$17,000
Coinsurance	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$9,500/\$19,000 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$75, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$150, no ded/\$100, no ded
Retail clinic	\$75, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	50% after ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$150, no ded/\$150, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	Subject to ded and \$700 per day ⁷
Inpatient professional services (includes maternity)	50% after ded
Emergency room (for copay plans, copay waived if admitted)	50% after ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$250, no ded/\$250, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50% after ded/50% after ded
Infusion — Home or office/Outpatient	50% after ded/50% after ded
Durable medical equipment and prosthetics	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$150, no ded/\$150, no ded
Inpatient mental health and substance abuse	Subject to ded and \$700 per day ⁷
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$750 after ded/\$1,000 after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$5, no ded
Retail generic ¹⁴	\$25, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$300
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400
Self-administered specialty drug ¹⁶	50% after ded
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Bronze health plans		Keystone HMO Bronze Proactive ² NEW		
Benefits per calendar year ¹		You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸		\$8,000/\$16,000	\$9,800/\$19,600	\$9,800/\$19,600
Coinsurance		20%, unless otherwise noted	30%, unless otherwise noted	40%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹		\$10,600/\$21,200 copay, ded, and coinsurance	\$10,600/\$21,200 copay, ded, and coinsurance	\$10,600/\$21,200 copay, ded, and coinsurance
Preventive services ⁵				
Preventive care for adults and children		0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers		0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based		\$750, no ded	\$750, no ded	\$750, no ded
Physician services				
Primary care visit — Office/Virtual		\$85, no ded/\$55, no ded	\$95, no ded/\$65, no ded	\$105, no ded/\$70, no ded
Specialist visit — Office/Virtual		\$170, no ded/\$115, no ded	\$180, no ded/\$120, no ded	\$190, no ded/\$125, no ded
Retail clinic ¹¹		\$85, no ded	\$95, no ded	\$105, no ded
Virtual care services from designated virtual provider ²⁵		0%, no ded	0%, no ded	0%, no ded
Urgent care		\$170, no ded	\$170, no ded	\$170, no ded
Spinal manipulations (20 visits per year)		\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Hospital and other medical services				
Inpatient hospital services (includes maternity)		Subject to ded and \$700 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)		20% after ded	30% after ded	40% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰		\$975, no ded	\$975, no ded	\$975, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based		\$200, no ded/\$200, no ded	\$200, no ded/\$200, no ded	\$200, no ded/\$200, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$400, no ded/\$400, no ded	\$400, no ded/\$400, no ded	\$400, no ded/\$400, no ded
Biotech/Specialty injectables — Home or office/Outpatient		50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient		20% after ded/20% after ded	30% after ded/30% after ded	40% after ded/40% after ded
Durable medical equipment and prosthetics		50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other		\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Inpatient mental health and substance abuse		Subject to ded and \$700 per day ⁷	Subject to ded and \$700 per day ⁷	Subject to ded and \$700 per day ⁷
Outpatient surgery				
Ambulatory surgical facility/Hospital-based		\$750 after ded/\$750 after ded	\$1,000 after ded/\$1,000 after ded	\$1,250 after ded/\$1,250 after ded
Outpatient lab and pathology				
Freestanding/Hospital-based		\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Prescription drugs ^{12,13,15}				
Deductible — Individual/Family ¹		\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴		\$7, no ded	\$7, no ded	\$7, no ded
Retail generic ¹⁴		\$35, no ded	\$35, no ded	\$35, no ded
Retail preferred brand ^{14,16}		50% after ded	50% after ded	50% after ded
Retail non-preferred drug ^{14,16}		50% after ded	50% after ded	50% after ded
Self-administered specialty drug ¹⁶		50% after ded	50% after ded	50% after ded
Additional benefits				
Vision ^{17,18}				
Pediatric exam and pediatric eyewear ^{19,20}		\$0, no ded	\$0, no ded	\$0, no ded
Dental ^{21,22}				
Pediatric dental deductible (per individual)		\$50	\$50	\$50
Pediatric exams and cleanings ²³		\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	50% after ded	50% after ded

Catastrophic health plan	Personal Choice [®] EPO Catastrophic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$10,600/\$21,200
Coinsurance	0%
Out-of-pocket maximum — Individual/Family	\$10,600/\$21,200 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	Visits 1 – 3: \$50 copay, no ded*/\$35 copay, no ded* Visits 4 +: 0% after ded*/0% after ded*
Specialist visit — Office/Virtual	0% after ded/0% after ded
Retail clinic	0% after ded
Virtual care services from designated virtual provider ²⁵	0% after ded
Urgent care	0% after ded
Spinal manipulations (20 visits per year)	0% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	0% after ded/0% after ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	0% after ded
Inpatient professional services (includes maternity)	0% after ded
Emergency room (for copay plans, copay 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 or office/Outpatient	0% after ded/0% after ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded
Durable medical equipment and prosthetics	0% after ded
Outpatient mental health and substance abuse — Office visit/All other	Visits 1 – 3: 0%, no ded/0% after ded Visits 4 +: 0% after ded/0% after ded
Inpatient mental health and substance abuse	0% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	0% after ded/0% after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	0% after ded/0% after ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	0% after ded
Retail generic ¹⁴	0% after ded
Retail preferred brand ^{14,16}	0% after ded
Retail non-preferred drug ^{14,16}	0% after ded
Self-administered specialty drug ¹⁶	0% after ded
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	Integrated with medical ded
Pediatric exams and cleanings ²³	0%, no ded
Pediatric basic, major, and orthodontia services ²⁴	0% after ded

2026 Cost-share Reduction Plans



Independence 

IBX

If you qualify for both lower monthly premiums and lower out-of-pocket costs based on the criteria on page 84, enroll in a Cost-share Reduction (or CSR) health plan on Pennie, the Pennsylvania Insurance Exchange.

Call us at **1-855-640-3454** if you would like help determining your eligibility or applying.

Cost-share Reduction Plans

Silver 200 – 249% CSR plans	Personal Choice [®] PPO Silver Classic ²	
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family	\$3,250/\$6,500	\$10,000/\$20,000
Coinsurance	30%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$6,900/\$13,800 copay, ded, and coinsurance	\$20,000/\$40,000 ded and coinsurance
Preventive services ⁵		
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 visit — Office/Virtual	\$30, no ded/\$20, no ded	50% after ded/50% after ded
Specialist visit — Office/Virtual	\$75, no ded/\$50, no ded	50% after ded/50% after ded
Retail clinic	\$30, no ded	50% after ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	Not covered
Urgent care	30% after ded	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$50, no ded	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶	\$75, no ded/\$75, no ded	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	20% after ded	50% after ded
Inpatient professional services (includes maternity)	20% after ded	50% after ded
Emergency room (for copay plans, copay waived if admitted)	30% after ded	30% after in-network ded
Routine radiology/diagnostic — Freestanding/Hospital-based	20% after ded/20% after ded	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	20% after ded/20% after ded	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	30% after ded/30% after ded	50% after ded/50% after ded
Infusion — Home or office/Outpatient	30% after ded/30% after ded	50% after ded/50% after ded
Durable medical equipment and prosthetics	30% after ded	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$75, no ded/20% after ded	50% after ded/50% after ded
Inpatient mental health and substance abuse	20% after ded	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	20% after ded/20% after ded	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	20%, no ded/50%, no ded	50% after ded/50% after ded
Prescription drugs ^{12,13,15}		
Deductible — Individual/Family	Integrated with medical ded	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded	70%, no ded
Retail generic ¹⁴	\$20, no ded	70%, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$200	70% after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$200	70% after ded
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	Not covered
Additional benefits		
Vision ^{17,18}		
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	Not covered
Dental ^{21,22}		
Pediatric dental deductible (per individual)	\$50	N/A
Pediatric exams and cleanings ²³	\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	Not covered

Silver 200 – 249% CSR plans	Keystone HMO Silver Classic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$3,500/\$7,000
Coinsurance	30%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$7,250/\$14,500 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$35, no ded/\$25, no ded
Specialist visit — Office/Virtual	\$70, no ded/\$50, no ded
Retail clinic	\$35, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	30% after ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$70, no ded/\$70, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	30% after ded
Inpatient professional services (includes maternity)	30% after ded
Emergency room (for copay plans, copay waived if admitted)	30% after ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$120, no ded/\$120, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$250, no ded/\$250, no ded
Biotech/Specialty injectables — Home or office/Outpatient	30% after ded/30% after ded
Infusion — Home or office/Outpatient	30% after ded/30% after ded
Durable medical equipment and prosthetics	30% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$70, no ded/\$70, no ded
Inpatient mental health and substance abuse	30% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$400, no ded/\$800, no ded
Outpatient lab and pathology	
Freestanding/Hospital-based	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded
Retail generic ¹⁴	\$15, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$300
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Cost-share Reduction Plans

Silver 200 – 249% CSR plans		Keystone HMO Silver Proactive ²		
Benefits per calendar year ¹		You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸		\$0/\$0	\$3,500/\$7,000	\$3,500/\$7,000
Coinsurance		0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹		\$7,400/\$14,800 copay and coinsurance	\$7,400/\$14,800 copay, ded, and coinsurance	\$7,400/\$14,800 copay, ded, and coinsurance
Preventive services ⁵				
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 visit — Office/Virtual		\$40/\$30	\$70, no ded/\$50, no ded	\$80, no ded/\$55, no ded
Specialist visit — Office/Virtual		\$90/\$65	\$140, no ded/\$100, no ded	\$150, no ded/\$105, no ded
Retail clinic ¹¹		\$40	\$70, no ded	\$80, no ded
Virtual care services from designated virtual provider ²⁵		0%	0%, no ded	0%, no ded
Urgent care		\$90	\$90, no ded	\$90, no ded
Spinal manipulations (20 visits per year)		\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Hospital and other medical services				
Inpatient hospital services (includes maternity)		\$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)		0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰		\$950	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based		\$150/\$150	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$375/\$375	\$375, no ded/\$375, no ded	\$375, no ded/\$375, no ded
Biotech/Specialty injectables — Home or office/Outpatient		50%/50%	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient		0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics		50%	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other		\$90/\$90	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Inpatient mental health and substance abuse		\$600 per day ⁷	\$600 per day, no ded ⁷	\$600 per day, no ded ⁷
Outpatient surgery				
Ambulatory surgical facility/Hospital-based		\$250/\$250	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology				
Freestanding/Hospital-based		\$10/\$10	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs ^{12,13,15}				
Deductible — Individual/Family [†]		\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴		\$7, no ded	\$7, no ded	\$7, no ded
Retail generic ¹⁴		\$25, no ded	\$25, no ded	\$25, no ded
Retail preferred brand ^{14,16}		\$100 after ded	\$100 after ded	\$100 after ded
Retail non-preferred drug ^{14,16}		50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶		50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits				
Vision ^{17,18}				
Pediatric exam and pediatric eyewear ^{19,20}		\$0	\$0, no ded	\$0, no ded
Dental ^{21,22}				
Pediatric dental deductible (per individual)		\$50	\$50	\$50
Pediatric exams and cleanings ²³		\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	50% after ded	50% after ded

Silver 200 – 249% CSR plans		Keystone HMO Silver Proactive Lite ²		
Benefits per calendar year ¹		You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸		\$2,000/\$4,000	\$6,500/\$13,000	\$6,500/\$13,000
Coinsurance		0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹		\$7,750/\$15,500 copay, ded, and coinsurance	\$7,750/\$15,500 copay, ded, and coinsurance	\$7,750/\$15,500 copay, ded, and coinsurance
Preventive services ⁵				
Preventive care for adults and children		0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers		0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based		\$750, no ded	\$750, no ded	\$750, no ded
Physician services				
Primary care visit — Office/Virtual		\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual		\$90, no ded/\$60, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹		\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵		0%, no ded	0%, no ded	0%, no ded
Urgent care		\$90, no ded	\$90, no ded	\$90, no ded
Spinal manipulations (20 visits per year)		\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based		\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Hospital and other medical services				
Inpatient hospital services (includes maternity)		Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)		0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰		\$950, no ded	\$950, no ded	\$950, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based		\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based		\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient		50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient		0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics		50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other		\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded	\$90, no ded/\$90, no ded
Inpatient mental health and substance abuse		Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery				
Ambulatory surgical facility/Hospital-based		Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology				
Freestanding/Hospital-based		\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs ^{12,13,15}				
Deductible — Individual/Family [†]		\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴		\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴		\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}		\$90 after ded	\$90 after ded	\$90 after ded
Retail non-preferred drug ^{14,16}		50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶		50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits				
Vision ^{17,18}				
Pediatric exam and pediatric eyewear ^{19,20}		\$0, no ded	\$0, no ded	\$0, no ded
Dental ^{21,22}				
Pediatric dental deductible (per individual)		\$50	\$50	\$50
Pediatric exams and cleanings ²³		\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}		50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 200 – 249% CSR plans	Keystone HMO Silver Basic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$5,000/\$10,000
Coinsurance	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$7,850/\$15,700 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$35, no ded/\$25, no ded
Specialist visit — Office/Virtual	\$80, no ded/\$55, no ded
Retail clinic	\$35, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	\$80, no ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$80, no ded/\$80, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	50% after ded
Inpatient professional services (includes maternity)	50% after ded
Emergency room (for copay plans, copay waived if admitted)	\$600, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$150, no ded/\$150, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$350, no ded/\$350, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50% after ded/50% after ded
Infusion — Home or office/Outpatient	50% after ded/50% after ded
Durable medical equipment and prosthetics	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$80, no ded/\$120, no ded
Inpatient mental health and substance abuse	50% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$1,650 after ded/\$1,650 after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded
Retail generic ¹⁴	\$15, no ded
Retail preferred brand ^{14,16}	50% after ded, up to \$300
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Silver 200 – 249% CSR plans	Keystone HMO Silver Proactive Basic ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$2,500/\$5,000	\$6,500/\$13,000	\$6,500/\$13,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$8,000/\$16,000 copay, ded, and coinsurance	\$8,000/\$16,000 copay, ded, and coinsurance	\$8,000/\$16,000 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$100, no ded/\$70, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$100, no ded	\$100, no ded	\$100, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$800, no ded	\$800, no ded	\$800, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$125, no ded/\$125, no ded	\$125, no ded/\$125, no ded	\$125, no ded/\$125, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$400	40% after ded, up to \$400	40% after ded, up to \$400
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 200 – 249% CSR plans	Keystone HMO Silver Proactive Essential ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$4,500/\$9,000	\$6,900/\$13,800	\$6,900/\$13,800
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$8,000/\$16,000 copay, ded, and coinsurance	\$8,000/\$16,000 copay, ded, and coinsurance	\$8,000/\$16,000 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750, no ded	\$750, no ded	\$750, no ded
Physician services			
Primary care visit — Office/Virtual	\$50, no ded/\$35, no ded	\$60, no ded/\$40, no ded	\$70, no ded/\$50, no ded
Specialist visit — Office/Virtual	\$100, no ded/\$70, no ded	\$120, no ded/\$80, no ded	\$140, no ded/\$95, no ded
Retail clinic ¹¹	\$50, no ded	\$60, no ded	\$70, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$100, no ded	\$100, no ded	\$100, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$600 per day ⁷	Subject to ded and \$900 per day ⁷	Subject to ded and \$1,300 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$750, no ded	\$750, no ded	\$750, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded	\$300, no ded/\$300, no ded
Biotech/Specialty injectables — Home or office/Outpatient	50%, no ded/50%, no ded	50%, no ded/50%, no ded	50%, no ded/50%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	50%, no ded	50%, no ded	50%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded	\$100, no ded/\$100, no ded
Inpatient mental health and substance abuse	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷	Subject to ded and \$600 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$250 copay/ Subject to ded and \$250 copay	Subject to ded and \$750 copay/ Subject to ded and \$750 copay	Subject to ded and \$1,250 copay/ Subject to ded and \$1,250 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family [†]	\$225/\$450	\$225/\$450	\$225/\$450
Low-cost generic ¹⁴	\$5, no ded	\$5, no ded	\$5, no ded
Retail generic ¹⁴	\$20, no ded	\$20, no ded	\$20, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$400	40% after ded, up to \$400	40% after ded, up to \$400
Retail non-preferred drug ^{14,16}	50% after ded, up to \$500	50% after ded, up to \$500	50% after ded, up to \$500
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000	50% after ded, up to \$1,000	50% after ded, up to \$1,000
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver 150 – 199% CSR plans	Personal Choice [®] PPO Silver Classic ²	
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family	\$2,250/\$4,500	\$10,000/\$20,000
Coinsurance	10%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$3,500/\$7,000 copay, ded, and coinsurance	\$20,000/\$40,000 ded and coinsurance
Preventive services ⁵		
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	\$500, no ded	50%, no ded
Physician services		
Primary care visit — Office/Virtual	\$25, no ded/\$20, no ded	50% after ded/50% after ded
Specialist visit — Office/Virtual	\$50, no ded/\$35, no ded	50% after ded/50% after ded
Retail clinic	\$25, no ded	50% after ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	Not covered
Urgent care	10% after ded	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$50, no ded	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶	\$50, no ded/\$50, no ded	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	10%, no ded	50% after ded
Inpatient professional services (includes maternity)	10%, no ded	50% after ded
Emergency room (for copay plans, copay waived if admitted)	10% after ded	10% after in-network ded
Routine radiology/diagnostic — Freestanding/Hospital-based	10%, no ded/10%, no ded	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	10%, no ded/10%, no ded	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	10% after ded/10% after ded	50% after ded/50% after ded
Infusion — Home or office/Outpatient	10% after ded/10% after ded	50% after ded/50% after ded
Durable medical equipment and prosthetics	10% after ded	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$50, no ded/10%, no ded	50% after ded/50% after ded
Inpatient mental health and substance abuse	10%, no ded	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	10%, no ded/10%, no ded	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	0%, no ded/50%, no ded	50% after ded/50% after ded
Prescription drugs ^{12,13,15}		
Deductible — Individual/Family	Integrated with medical ded	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded	70%, no ded
Retail generic ¹⁴	\$10, no ded	70%, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$200	70% after ded
Retail non-preferred drug ^{14,16}	50% after ded, up to \$200	70% after ded
Self-administered specialty drug ¹⁶	50% after ded, up to \$500	Not covered
Additional benefits		
Vision ^{17,18}		
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	Not covered
Dental ^{21,22}		
Pediatric dental deductible (per individual)	\$50	N/A
Pediatric exams and cleanings ²³	\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	Not covered

Cost-share Reduction Plans

Silver 150 – 199% CSR plans	Keystone HMO Silver Classic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$1,000/\$2,000
Coinsurance	20%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$2,500/\$5,000 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$30, no ded/\$20, no ded
Specialist visit — Office/Virtual	\$60, no ded/\$40, no ded
Retail clinic	\$30, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	20% after ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$60, no ded/\$60, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	20% after ded
Inpatient professional services (includes maternity)	20% after ded
Emergency room (for copay plans, copay waived if admitted)	20% after ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$50, no ded/\$50, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$100, no ded/\$100, no ded
Biotech/Specialty injectables — Home or office/Outpatient	20% after ded/20% after ded
Infusion — Home or office/Outpatient	20% after ded/20% after ded
Durable medical equipment and prosthetics	20% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$60, no ded/\$60, no ded
Inpatient mental health and substance abuse	20% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$200, no ded/\$400, no ded
Outpatient lab and pathology	
Freestanding/Hospital-based	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded
Retail generic ¹⁴	\$10, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$200
Retail non-preferred drug ^{14,16}	50% after ded, up to \$200
Self-administered specialty drug ¹⁶	50% after ded, up to \$500
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Silver 150 – 199% CSR plans	Keystone HMO Silver Proactive ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$3,500/\$7,000 copay and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$20/\$15	\$30, no ded/\$20, no ded	\$40, no ded/\$30, no ded
Specialist visit — Office/Virtual	\$40/\$30	\$60, no ded/\$40, no ded	\$80, no ded/\$55, no ded
Retail clinic ¹¹	\$20	\$30, no ded	\$40, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$40	\$40, no ded	\$40, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$40/\$40	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$200 per day ⁷	Subject to ded and \$500 per day ⁷	Subject to ded and \$900 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$450	\$450, no ded	\$450, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$75/\$75	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$200/\$200	\$200, no ded/\$200, no ded	\$200, no ded/\$200, no ded
Biotech/Specialty injectables — Home or office/Outpatient	40%/40%	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$40/\$40	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Inpatient mental health and substance abuse	\$200 per day ⁷	\$200 per day, no ded ⁷	\$200 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$100/\$100	Subject to ded and \$450 copay/ Subject to ded and \$450 copay	Subject to ded and \$900 copay/ Subject to ded and \$900 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$10/\$10	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$3	\$3	\$3
Retail generic ¹⁴	\$10	\$10	\$10
Retail preferred brand ^{14,16}	\$100	\$100	\$100
Retail non-preferred drug ^{14,16}	40%, up to \$400	40%, up to \$400	40%, up to \$400
Self-administered specialty drug ¹⁶	50%, up to \$500	50%, up to \$500	50%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 150 – 199% CSR plans	Keystone HMO Silver Proactive Lite ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$1,000/\$2,000	\$2,000/\$4,000	\$2,000/\$4,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance
Preventive services ⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$500, no ded	\$500, no ded	\$500, no ded
Physician services			
Primary care visit — Office/Virtual	\$20, no ded/\$15, no ded	\$30, no ded/\$20, no ded	\$40, no ded/\$30, no ded
Specialist visit — Office/Virtual	\$40, no ded/\$30, no ded	\$60, no ded/\$40, no ded	\$80, no ded/\$55, no ded
Retail clinic ¹¹	\$20, no ded	\$30, no ded	\$40, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$40, no ded	\$40, no ded	\$40, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$300 per day ⁷	Subject to ded and \$500 per day ⁷	Subject to ded and \$900 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$250, no ded	\$250, no ded	\$250, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Biotech/Specialty injectables — Home or office/Outpatient	40%, no ded/40%, no ded	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%, no ded	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Inpatient mental health and substance abuse	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$100 copay/ Subject to ded and \$100 copay	Subject to ded and \$450 copay/ Subject to ded and \$450 copay	Subject to ded and \$900 copay/ Subject to ded and \$900 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs ^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$3	\$3	\$3
Retail generic ¹⁴	\$10	\$10	\$10
Retail preferred brand ^{14,16}	\$90	\$90	\$90
Retail non-preferred drug ^{14,16}	40%, up to \$400	40%, up to \$400	40%, up to \$400
Self-administered specialty drug ¹⁶	50%, up to \$500	50%, up to \$500	50%, up to \$500
Additional benefits			
Vision ^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental ^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver 150 – 199% CSR plans	Keystone HMO Silver Basic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$1,000/\$2,000
Coinsurance	30%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$3,000/\$6,000 copay, ded, and coinsurance
Preventive services⁵	
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 visit — Office/Virtual	\$20, no ded/\$15, no ded
Specialist visit — Office/Virtual	\$40, no ded/\$30, no ded
Retail clinic	\$20, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded
Urgent care	\$40, no ded
Spinal manipulations (20 visits per year)	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$40, no ded/\$40, no ded
Hospital and other medical services	
Inpatient hospital services (includes maternity)	30% after ded
Inpatient professional services (includes maternity)	30% after ded
Emergency room (for copay plans, copay waived if admitted)	\$250, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$75, no ded/\$75, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$150, no ded/\$150, no ded
Biotech/Specialty injectables — Home or office/Outpatient	30% after ded/30% after ded
Infusion — Home or office/Outpatient	30% after ded/30% after ded
Durable medical equipment and prosthetics	30% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$40, no ded/\$70, no ded
Inpatient mental health and substance abuse	30% after ded
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$1,000 after ded/\$1,000 after ded
Outpatient lab and pathology	
Freestanding/Hospital-based	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	Integrated with medical ded
Low-cost generic ¹⁴	\$3, no ded
Retail generic ¹⁴	\$10, no ded
Retail preferred brand ^{14,16}	40% after ded, up to \$300
Retail non-preferred drug ^{14,16}	50% after ded, up to \$400
Self-administered specialty drug ¹⁶	50% after ded, up to \$1,000
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Cost-share Reduction Plans

Silver 150 – 199% CSR plans	Keystone HMO Silver Proactive Basic ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$1,000/\$2,000	\$2,000/\$4,000	\$2,000/\$4,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$500, no ded	\$500, no ded	\$500, no ded
Physician services			
Primary care visit — Office/Virtual	\$20, no ded/\$15, no ded	\$30, no ded/\$20, no ded	\$40, no ded/\$30, no ded
Specialist visit — Office/Virtual	\$40, no ded/\$30, no ded	\$60, no ded/\$40, no ded	\$80, no ded/\$55, no ded
Retail clinic ¹¹	\$20, no ded	\$30, no ded	\$40, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$40, no ded	\$40, no ded	\$40, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$300 per day ⁷	Subject to ded and \$500 per day ⁷	Subject to ded and \$900 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$250, no ded	\$250, no ded	\$250, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Biotech/Specialty injectables — Home or office/Outpatient	40%, no ded/40%, no ded	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%, no ded	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Inpatient mental health and substance abuse	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$100 copay/ Subject to ded and \$100 copay	Subject to ded and \$450 copay/ Subject to ded and \$450 copay	Subject to ded and \$900 copay/ Subject to ded and \$900 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$3	\$3	\$3
Retail generic ¹⁴	\$10	\$10	\$10
Retail preferred brand ^{14,16}	30%, up to \$300	30%, up to \$300	30%, up to \$300
Retail non-preferred drug ^{14,16}	40%, up to \$400	40%, up to \$400	40%, up to \$400
Self-administered specialty drug ¹⁶	50%, up to \$500	50%, up to \$500	50%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver 150 – 199% CSR plans	Keystone HMO Silver Proactive Essential ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$1,500/\$3,000	\$2,000/\$4,000	\$2,000/\$4,000
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance	\$3,500/\$7,000 copay, ded, and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%, no ded	0%, no ded	0%, no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$500, no ded	\$500, no ded	\$500, no ded
Physician services			
Primary care visit — Office/Virtual	\$20, no ded/\$15, no ded	\$30, no ded/\$20, no ded	\$40, no ded/\$30, no ded
Specialist visit — Office/Virtual	\$40, no ded/\$30, no ded	\$60, no ded/\$40, no ded	\$80, no ded/\$55, no ded
Retail clinic ¹¹	\$20, no ded	\$30, no ded	\$40, no ded
Virtual care services from designated virtual provider ²⁵	0%, no ded	0%, no ded	0%, no ded
Urgent care	\$40, no ded	\$40, no ded	\$40, no ded
Spinal manipulations (20 visits per year)	\$50, no ded	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and \$300 per day ⁷	Subject to ded and \$500 per day ⁷	Subject to ded and \$900 per day ⁷
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$250, no ded	\$250, no ded	\$250, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded	\$75, no ded/\$75, no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded	\$150, no ded/\$150, no ded
Biotech/Specialty injectables — Home or office/Outpatient	40%, no ded/40%, no ded	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%, no ded	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded	\$40, no ded/\$40, no ded
Inpatient mental health and substance abuse	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷	Subject to ded and \$300 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	Subject to ded and \$100 copay/ Subject to ded and \$100 copay	Subject to ded and \$450 copay/ Subject to ded and \$450 copay	Subject to ded and \$900 copay/ Subject to ded and \$900 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded	\$10, no ded/\$10, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$3	\$3	\$3
Retail generic ¹⁴	\$15	\$15	\$15
Retail preferred brand ^{14,16}	30%, up to \$300	30%, up to \$300	30%, up to \$300
Retail non-preferred drug ^{14,16}	40%, up to \$400	40%, up to \$400	40%, up to \$400
Self-administered specialty drug ¹⁶	50%, up to \$500	50%, up to \$500	50%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0, no ded	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 138 – 149% CSR plans	Personal Choice [®] PPO Silver Classic ²	
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Deductible — Individual/Family	\$0/\$0	\$10,000/\$20,000
Coinsurance	10%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$2,500/\$5,000 copay and coinsurance	\$20,000/\$40,000 ded and coinsurance
Preventive services ⁵		
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	\$250	50%, no ded
Physician services		
Primary care visit — Office/Virtual	\$5/\$0	50% after ded/50% after ded
Specialist visit — Office/Virtual	\$10/\$5	50% after ded/50% after ded
Retail clinic	\$5	50% after ded
Virtual care services from designated virtual provider ²⁵	\$0	Not covered
Urgent care	10%	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$10	50% after ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based ⁶	\$10/\$10	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	10%	50% after ded
Inpatient professional services (includes maternity)	10%	50% after ded
Emergency room (for copay plans, copay waived if admitted)	10%	10%, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	10%/10%	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	10%/10%	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	10%/10%	50% after ded/50% after ded
Infusion — Home or office/Outpatient	10%/10%	50% after ded/50% after ded
Durable medical equipment and prosthetics	10%	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	\$10/10%	50% after ded/50% after ded
Inpatient mental health and substance abuse	10%	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	10%/10%	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	0%/50%	50% after ded/50% after ded
Prescription drugs ^{12,13,15}		
Deductible — Individual/Family	None	None
Low-cost generic ¹⁴	\$3	70%
Retail generic ¹⁴	\$4	70%
Retail preferred brand ^{14,16}	15%, up to \$200	70%
Retail non-preferred drug ^{14,16}	15%, up to \$200	70%
Self-administered specialty drug ¹⁶	50%, up to \$500	Not covered
Additional benefits		
Vision ^{17,18}		
Pediatric exam and pediatric eyewear ^{19,20}	\$0	Not covered
Dental ^{21,22}		
Pediatric dental deductible (per individual)	\$50	N/A
Pediatric exams and cleanings ²³	\$0, no ded	Not covered
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	Not covered

Silver 138 – 149% CSR plans	Keystone HMO Silver Classic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$0/\$0
Coinsurance	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$1,900/\$3,800 copay and coinsurance
Preventive services⁵	
Preventive care for adults and children	\$0
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	\$0
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750
Physician services	
Primary care visit — Office/Virtual	\$10/\$5
Specialist visit — Office/Virtual	\$20/\$15
Retail clinic	\$10
Virtual care services from designated virtual provider ²⁵	\$0
Urgent care	10%
Spinal manipulations (20 visits per year)	\$50
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$20/\$20
Hospital and other medical services	
Inpatient hospital services (includes maternity)	10%
Inpatient professional services (includes maternity)	10%
Emergency room (for copay plans, copay waived if admitted)	10%
Routine radiology/diagnostic — Freestanding/Hospital-based	\$10/\$10
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$20/\$20
Biotech/Specialty injectables — Home or office/Outpatient	10%/10%
Infusion — Home or office/Outpatient	10%/10%
Durable medical equipment and prosthetics	10%
Outpatient mental health and substance abuse — Office visit/All other	\$20/\$20
Inpatient mental health and substance abuse	10%
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$40/\$80
Outpatient lab and pathology	
Freestanding/Hospital-based	\$5/\$5
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	None
Low-cost generic ¹⁴	\$3
Retail generic ¹⁴	\$4
Retail preferred brand ^{14,16}	5%, up to \$200
Retail non-preferred drug ^{14,16}	15%, up to \$200
Self-administered specialty drug ¹⁶	50%, up to \$500
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Cost-share Reduction Plans

Silver 138 – 149% CSR plans	Keystone HMO Silver Proactive ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$1,900/\$3,800 copay and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$5/\$0	\$10, no ded/\$5, no ded	\$20, no ded/\$15, no ded
Specialist visit — Office/Virtual	\$15/\$10	\$20, no ded/\$15, no ded	\$40, no ded/\$30, no ded
Retail clinic ¹¹	\$5	\$10, no ded	\$20, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$15	\$15, no ded	\$15, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$50 per day ⁷	Subject to ded and \$250 per day ⁷	Subject to ded and \$500 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$50	\$50, no ded	\$50, no ded
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 or office/Outpatient	40%/40%	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Inpatient mental health and substance abuse	\$50 per day ⁷	\$50 per day, no ded ⁷	\$50 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$50/\$50	Subject to ded and \$200 copay/ Subject to ded and \$200 copay	Subject to ded and \$400 copay/ Subject to ded and \$400 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$5/\$5	\$5, no ded/\$5, no ded	\$5, no ded/\$5, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$1	\$1	\$1
Retail generic ¹⁴	\$4	\$4	\$4
Retail preferred brand ^{14,16}	\$15	\$15	\$15
Retail non-preferred drug ^{14,16}	5%, up to \$400	5%, up to \$400	5%, up to \$400
Self-administered specialty drug ¹⁶	30%, up to \$500	30%, up to \$500	30%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Silver 138 – 149% CSR plans	Keystone HMO Silver Proactive Lite ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$1,900/\$3,800 copay and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$5/\$0	\$10, no ded/\$5, no ded	\$20, no ded/\$15, no ded
Specialist visit — Office/Virtual	\$15/\$10	\$20, no ded/\$15, no ded	\$40, no ded/\$30, no ded
Retail clinic ¹¹	\$5	\$10, no ded	\$20, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$15	\$15, no ded	\$15, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$50 per day ⁷	Subject to ded and \$250 per day ⁷	Subject to ded and \$500 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$50	\$50, no ded	\$50, no ded
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 or office/Outpatient	40%/40%	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Inpatient mental health and substance abuse	\$50 per day ⁷	\$50 per day, no ded ⁷	\$50 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$50 copay/\$50 copay	Subject to ded and \$200 copay/ Subject to ded and \$200 copay	Subject to ded and \$400 copay/ Subject to ded and \$400 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$5/\$5	\$5, no ded/\$5, no ded	\$5, no ded/\$5, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$1	\$1	\$1
Retail generic ¹⁴	\$4	\$4	\$4
Retail preferred brand ^{14,16}	\$15	\$15	\$15
Retail non-preferred drug ^{14,16}	5%, up to \$400	5%, up to \$400	5%, up to \$400
Self-administered specialty drug ¹⁶	30%, up to \$500	30%, up to \$500	30%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 138 – 149% CSR plans	Keystone HMO Silver Basic ²
Benefits per calendar year¹	You pay in-network³
Deductible — Individual/Family	\$0/\$0
Coinsurance	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	\$1,650/\$3,300 copay and coinsurance
Preventive services⁵	
Preventive care for adults and children	\$0
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	\$0
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750
Physician services	
Primary care visit — Office/Virtual	\$15/\$10
Specialist visit — Office/Virtual	\$30/\$20
Retail clinic	\$15
Virtual care services from designated virtual provider ²⁵	\$0
Urgent care	\$30
Spinal manipulations (20 visits per year)	\$50
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$30/\$30
Hospital and other medical services	
Inpatient hospital services (includes maternity)	10%
Inpatient professional services (includes maternity)	10%
Emergency room (for copay plans, copay waived if admitted)	\$50
Routine radiology/diagnostic — Freestanding/Hospital-based	\$15/\$15
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$30/\$30
Biotech/Specialty injectables — Home or office/Outpatient	10%/10%
Infusion — Home or office/Outpatient	10%/10%
Durable medical equipment and prosthetics	10%
Outpatient mental health and substance abuse — Office visit/All other	\$30/\$30
Inpatient mental health and substance abuse	10%
Outpatient surgery	
Ambulatory surgical facility/Hospital-based	\$75/\$75
Outpatient lab and pathology	
Freestanding/Hospital-based	\$5/\$5
Prescription drugs^{12,13,15}	
Deductible — Individual/Family	None
Low-cost generic ¹⁴	\$3
Retail generic ¹⁴	\$4
Retail preferred brand ^{14,16}	5%, up to \$300
Retail non-preferred drug ^{14,16}	15%, up to \$400
Self-administered specialty drug ¹⁶	50%, up to \$1,000
Additional benefits	
Vision^{17,18}	
Pediatric exam and pediatric eyewear ^{19,20}	\$0
Dental^{21,22}	
Pediatric dental deductible (per individual)	\$50
Pediatric exams and cleanings ²³	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded

Silver 138 – 149% CSR plans	Keystone HMO Silver Proactive Basic ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family ⁸	\$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 ⁹	\$1,900/\$3,800 copay and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance	\$1,900/\$3,800 copay, ded, and coinsurance
Preventive services⁵			
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 visit — Office/Virtual	\$5/\$0	\$10, no ded/\$5, no ded	\$20, no ded/\$15, no ded
Specialist visit — Office/Virtual	\$15/\$10	\$20, no ded/\$15, no ded	\$40, no ded/\$30, no ded
Retail clinic ¹¹	\$5	\$10, no ded	\$20, no ded
Virtual care services from designated virtual provider ²⁵	0%	0%, no ded	0%, no ded
Urgent care	\$15	\$15, no ded	\$15, no ded
Spinal manipulations (20 visits per year)	\$50	\$50, no ded	\$50, no ded
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$50 per day ⁷	Subject to ded and \$250 per day ⁷	Subject to ded and \$500 per day ⁷
Inpatient professional services (includes maternity)	0%	5% after ded	10% after ded
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$50	\$50, no ded	\$50, no ded
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 or office/Outpatient	40%/40%	40%, no ded/40%, no ded	40%, no ded/40%, no ded
Infusion — Home or office/Outpatient	0%/0%	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment and prosthetics	20%	20%, no ded	20%, no ded
Outpatient mental health and substance abuse — Office visit/All other	\$15/\$15	\$15, no ded/\$15, no ded	\$15, no ded/\$15, no ded
Inpatient mental health and substance abuse	\$50 per day ⁷	\$50 per day, no ded ⁷	\$50 per day, no ded ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$50/\$50	Subject to ded and \$200 copay/ Subject to ded and \$200 copay	Subject to ded and \$400 copay/ Subject to ded and \$400 copay
Outpatient lab and pathology			
Freestanding/Hospital-based	\$5/\$5	\$5, no ded/\$5, no ded	\$5, no ded/\$5, no ded
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$1	\$1	\$1
Retail generic ¹⁴	\$4	\$4	\$4
Retail preferred brand ^{14,16}	5%, up to \$300	5%, up to \$300	5%, up to \$300
Retail non-preferred drug ^{14,16}	5%, up to \$400	5%, up to \$400	5%, up to \$400
Self-administered specialty drug ¹⁶	30%, up to \$500	30%, up to \$500	30%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0, no ded	\$0, no ded
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Cost-share Reduction Plans

Silver 138 – 149% CSR plans	Keystone HMO Silver Proactive Essential ²		
Benefits per calendar year ¹	You pay in-network ³ Tier 1 – Preferred	You pay in-network ³ Tier 2 – Enhanced	You pay in-network ³ Tier 3 – Standard
Deductible — Individual/Family	\$0/\$0	\$0/\$0	\$0/\$0
Coinsurance	0%, unless otherwise noted	5%, unless otherwise noted	10%, unless otherwise noted
Out-of-pocket maximum — Individual/Family ⁹	\$2,000/\$4,000 copay and coinsurance	\$2,000/\$4,000 copay and coinsurance	\$2,000/\$4,000 copay and coinsurance
Preventive services⁵			
Preventive care for adults and children	0%	0%	0%
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0%	0%	0%
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$250	\$250	\$250
Physician services			
Primary care visit — Office/Virtual	\$5/\$0	\$10/\$5	\$20/\$15
Specialist visit — Office/Virtual	\$15/\$10	\$20/\$15	\$40/\$30
Retail clinic ¹¹	\$5	\$10	\$20
Virtual care services from designated virtual provider ²⁵	0%	0%	0%
Urgent care	\$15	\$15	\$15
Spinal manipulations (20 visits per year)	\$50	\$50	\$50
Physical/Occupational therapy (30 visits per year) — Freestanding/Hospital-based	\$15/\$15	\$15/\$15	\$15/\$15
Hospital and other medical services			
Inpatient hospital services (includes maternity)	\$50 per day ⁷	\$250 per day ⁷	\$500 per day ⁷
Inpatient professional services (includes maternity)	0%	5%	10%
Emergency room (for copay plans, copay waived if admitted) ¹⁰	\$50	\$50	\$50
Routine radiology/diagnostic — Freestanding/Hospital-based	\$10/\$10	\$10/\$10	\$10/\$10
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$20/\$20	\$20/\$20	\$20/\$20
Biotech/Specialty injectables — Home or office/Outpatient	40%/40%	40%/40%	40%/40%
Infusion — Home or office/Outpatient	0%/0%	5%/5%	10%/10%
Durable medical equipment and prosthetics	20%	20%	20%
Outpatient mental health and substance abuse — Office visit/All other	\$15/\$15	\$15/\$15	\$15/\$15
Inpatient mental health and substance abuse	\$50 per day ⁷	\$50 per day ⁷	\$50 per day ⁷
Outpatient surgery			
Ambulatory surgical facility/Hospital-based	\$50/\$50	\$200/\$200	\$400/\$400
Outpatient lab and pathology			
Freestanding/Hospital-based	\$5/\$5	\$5/\$5	\$5/\$5
Prescription drugs^{12,13,15}			
Deductible — Individual/Family	None	None	None
Low-cost generic ¹⁴	\$1	\$1	\$1
Retail generic ¹⁴	\$10	\$10	\$10
Retail preferred brand ^{14,16}	5%, up to \$300	5%, up to \$300	5%, up to \$300
Retail non-preferred drug ^{14,16}	5%, up to \$400	5%, up to \$400	5%, up to \$400
Self-administered specialty drug ¹⁶	30%, up to \$500	30%, up to \$500	30%, up to \$500
Additional benefits			
Vision^{17,18}			
Pediatric exam and pediatric eyewear ^{19,20}	\$0	\$0	\$0
Dental^{21,22}			
Pediatric dental deductible (per individual)	\$50	\$50	\$50
Pediatric exams and cleanings ²³	\$0, no ded	\$0, no ded	\$0, no ded
Pediatric basic, major, and orthodontia services ^{24,29}	50% after ded	50% after ded	50% after ded

Dental and vision plans



Independence 

IBX

Dental plans

Stand-alone dental plans are available for adults ages 19 and older and families with children up to age 26.

Learn more about our dental plans

NEW There are three new family plans available for 2026 coverage.

Here are the comprehensive benefits you can expect from IBX dental plans.



A network that goes the distance

You have access to one of the largest dental networks in the region and a national network with more than 500,000 access points.



Full coverage on most preventive and diagnostic services

Fully covered services include routine exams, cleanings, and X-rays. You pay \$0 cost-sharing with an in-network provider.



Coverage for most basic and major services

There's no waiting period for preventive care and certain basic services like fillings and extractions. Review the benefits for each plan to see how major services are covered and if waiting periods apply.

Note: Pediatric dental coverage is included in all IBX individual and family medical plans.



Flexibility to see any dentist you want

With our PPO dental plans, you'll maximize your savings using an in-network dentist, but you can see any dentist you want without a referral. Our new EPO dental plan includes in-network coverage only.



NEW Rewards for getting preventive care

The primary subscriber will receive \$20 for each insured family member who gets two cleanings from an in-network dentist in the plan year. For example, for a family of four, the primary subscriber would receive \$80 if each family member gets two cleanings that meet the criteria.

Next step: Apply!

There are several ways to enroll in an adult dental plan:



- Visit ibx.com/enrolldental.
- Call to speak with one of our licensed sales agents at 1-855-640-3454 (TTY: 711).
- Stop by Independence LIVE on the 2nd floor of 1919 Market Street in Philadelphia for help from a licensed sales agent. Visit ibx.com/events to see our hours.

Choose your dental plan

Refer to the benefit overviews to learn more about our 2026 adult and family dental plans. These plans are available for adults ages 19 and older and families with children up to age 26.

Plan description ^{1,2}	IBX Adult Preferred Dental PPO	IBX Adult Premier Dental PPO ²⁶
In-network benefits		
Annual deductible — Individual/family	\$50/\$150	\$50/\$150
Annual maximum dental benefit	\$1,500 per insured person	\$2,000 per insured person
Reimbursement		
In-network/Out-of-network	IBX Dental PPO Network/MAC*	IBX Dental PPO Network/MAC*
Benefit (% paid by plan)	In-network & out-of-network	In-network & out-of-network
Exams and cleanings	100%	100%
Extra cleaning — Pregnancy	100%	100%
Preventive reward (in-network only)	\$20 payment to the subscriber	\$20 payment to the subscriber
Radiographs (all X-rays)	100%	100%
Fluoride treatments and sealants	Not covered	Not covered
Teledentistry, synchronous or asynchronous	100%	100%
Space maintainers	Not covered	Not covered
Restorative services (including white fillings)	50% after deductible	80% after deductible
Endodontic therapy (e.g., root canals)	50% after deductible (12-month waiting period)	80% after deductible (12-month waiting period)
Periodontics services (surgical and non-surgical)	50% after deductible (12-month waiting period)	80% after deductible (12-month waiting period)
Oral surgery	50% after deductible (12-month waiting period)	80% after deductible (12-month waiting period)
General anesthesia, nitrous oxide, and/or iv sedation	50% after deductible (12-month waiting period)	80% after deductible (12-month waiting period)
Crowns, inlays, and onlays	Not covered	50% after deductible (12-month waiting period)
Prosthetics (bridges, dentures)	Not covered	50% after deductible (12-month waiting period)
Implant services	Not covered	Not covered
Repairs and adjustments (crowns, inlays, onlays, bridges, and dentures)	50% after deductible (12-month waiting period)	80% after deductible (12-month waiting period)
Orthodontics	Not covered	Not covered

Monthly premiums per member

Age	IBX Adult Preferred Dental PPO	IBX Adult Premier Dental PPO ¹
19 – 25	\$18.89	\$39.39
26 – 39	\$20.07	\$41.85
40 – 49	\$23.61	\$49.24
50 – 63	\$27.74	\$57.86
64+	\$28.33	\$59.09

* MAC – Maximum allowable charge: This is the amount that is paid for out-of-network services as determined by Independence Blue Cross. If a member goes out of network, they may be balanced billed for the difference between the reimbursement amount and the provider's charge.

Rates are subject to change pending approval from the Pennsylvania Insurance Department. Independence Blue Cross dental plans are underwritten by QCC Insurance Company.

Dental plans (continued)

NEW Our new dental plans for 2026 offer coverage for all family members, shorter waiting periods, and orthodontia coverage.

Plan description ^{1,2}	IBX PPO 100/50/30/0 \$1,000 (MAC) ^{*,26}	IBX Active PPO 100/80/50/50 \$1,500 (MAC) ^{*,26}
In-network benefits		
Annual deductible — Individual/family	\$50/\$150	\$50/\$150
Annual maximum dental benefit per insured person	\$1,000	\$1,500
Orthodontia lifetime maximum per insured person under age 19	Not covered	\$1,000
Reimbursement		
In-network/Out-of-network	IBX Dental PPO Network/MAC*	
Benefit (% paid by plan)	In-network & out-of-network*	In-network/out-of-network*
Exams and cleanings	100%	100%/90%
Extra cleaning — Pregnancy	100%	100%/90%
Preventive reward (in-network only)	\$20 payment to the subscriber	\$20 payment to the subscriber
Radiographs (all X-rays)	100%	100%/90%
Fluoride treatments and sealants	100%	100%/90%
Teledentistry, synchronous or asynchronous	100%	100%/90%
Space maintainers	100%	100%/90%
Restorative services (including white fillings)	50% after deductible	80%/70% after deductible
Endodontic therapy (e.g., root canals)	50% after deductible	80%/70% after deductible
Periodontics services (surgical and non-surgical)	50% after deductible	80%/70% after deductible
Oral surgery	50% after deductible	80%/70% after deductible
General anesthesia, nitrous oxide, and/or IV sedation	50% after deductible	80%/70% after deductible
Crowns, inlays, and onlays	30% after deductible (3-month waiting period)	50%/40% after deductible (6-month waiting period)
Prosthetics (bridges, dentures)	30% after deductible (3-month waiting period)	50%/40% after deductible (6-month waiting period)
Implant services	Not covered	Not covered
Repairs and adjustments (crowns, inlays, onlays, bridges, and dentures)	50% after deductible	80%/70% after deductible
Orthodontics (up to age 19)	Not covered	50%/50% (12-month waiting period)

Monthly premiums per member

Age	IBX PPO 100/50/30/0 \$1,000 (MAC)*	IBX Active PPO 100/80/50/50 \$1,500 (MAC)*
0 – 18	\$32.10	\$45.60
19 – 25	\$31.68	\$38.56
26 – 39	\$33.66	\$40.97
40 – 49	\$39.60	\$48.20
50 – 63	\$46.53	\$56.64
64 +	\$47.52	\$57.84

* MAC – Maximum allowable charge: This is the amount that is paid for out-of-network services as determined by Independence Blue Cross. If a member goes out of network, they may be balanced billed for the difference between the reimbursement amount and the provider's charge.

Rates are subject to change pending approval from the Pennsylvania Insurance Department. Independence Blue Cross dental plans are underwritten by QCC Insurance Company.

Dental plans (continued)

The IBX EPO Low plan is an in-network only copay-based plan. Copay ranges displayed below cover a wide range of services within a certain benefit category. Please see the policy for exact procedures covered and corresponding copay amounts.

Plan description ^{1,2}	IBX EPO Low (in-network only plan)
In-network benefits	
Annual deductible — Individual/family	\$25/\$75
Annual maximum dental benefit per insured person	\$2,000
Orthodontia lifetime maximum per insured person under age 19	Not covered
Reimbursement	
In-network	IBX Dental PPO Network (in-network only plan)
Benefit	In-network copay*
Exams and cleanings	\$0 – \$40
Extra cleaning — Pregnancy	\$0 – \$40
Preventive reward (in-network only)	\$20 payment to the subscriber
Radiographs (all X-rays)	\$0 – \$0
Fluoride treatments and sealants	\$0 – \$18
Teledentistry, synchronous or asynchronous	\$20 (3-month waiting period)
Space maintainers	\$30 – \$115
Restorative services (including white fillings)	\$15 – \$115
Endodontic therapy (e.g., root canals)	\$10 – \$780 (3-month waiting period)
Periodontics services (surgical and non-surgical)	\$23 – \$626 (3-month waiting period)
Oral surgery	\$29 – \$2,300 (3-month waiting period)
General anesthesia, nitrous oxide, and/or IV sedation	\$0 – \$117 (3-month waiting period)
Crowns, inlays, and onlays	\$20 – \$625 (3-month waiting period)
Prosthetics (bridges, dentures)	\$20 – \$625 (3-month waiting period)
Implant services	\$24 – \$1,360 (3-month waiting period)
Repairs and adjustments (crowns, inlays, onlays, bridges, and dentures)	\$20 – \$625 (3-month waiting period)
Orthodontics	Not covered
Rollover covered†	Yes
Rollover threshold	\$1,000
Rollover max	\$2,500

Monthly premiums per member

Age	IBX EPO Low
0 – 18	\$27.20
19 – 25	\$26.44
26 – 39	\$28.09
40 – 49	\$33.05
50 – 63	\$38.83
64+	\$39.66

* Copay ranges vary greatly based on the service. Please see the benefit booklet for the exact copay of each service and whether it is covered.

† Please see benefit booklet for additional details and requirements in order to be eligible for the Rollover Benefit.

Rates are subject to change pending approval from the Pennsylvania Insurance Department. Independence Blue Cross dental plans are underwritten by QCC Insurance Company.

Vision plans

Stand-alone vision plans are available for adults ages 19 and older and families with children up to age 26.

Learn more about our vision plans

Here are the comprehensive benefits you can expect from IBX vision plans.



A network that goes the distance

You get access to the national Davis Vision® network, with 198,000 access points across the country, including Visionworks®, Target Optical, Pearle Vision, Warby Parker, and new this year, LensCrafters.*

198,000 access points
in the Davis Vision
provider network



Fully covered routine annual eye exam

When you see an in-network provider, there is no copay.



\$0 copay and low-cost options for frames and lenses

Choose from stylish designer frames in the Davis Vision Exclusive Collection. Or use your benefit allowance to choose frames or contact lenses from in-network independent providers and retailers nationwide.

You get an extra \$50 frame allowance and discounts on lens options at more than 750+ Visionworks locations nationwide. If by day 100, you don't love your new glasses, Visionworks will exchange them.

Note: Pediatric vision coverage is included in all IBX individual and family medical plans.



Fixed fee pricing on all cosmetic lens options

Your options include a wide variety of state-of-the-art lens types and lens styles.



Discounts on other services

Take advantage of discounts on other services, such as laser eye correction, hearing exams, and name-brand hearing aid technology from Your Hearing Network.

Next step: Apply!

There are several ways to enroll in a vision plan:



- Visit ibx.com/enrollvision.
- Call to speak with one of our licensed sales agents at 1-855-640-3454 (TTY: 711).
- Stop by Independence LIVE on the 2nd floor of 1919 Market Street in Philadelphia for help from a licensed sales agent. Visit ibx.com/events to see our hours.

* Warby Parker, Target Optical, LensCrafters, and Pearle Vision are out-of-network for pediatric members in ACA medical plans. These providers are in-network for our stand-alone adult and family vision plans.

Choose a vision plan

Refer to the benefit overviews to learn more about our 2026 adult and family vision plans. These plans are available for adults ages 19 and older and families with children up to age 26.

	Vision Care 150	Vision Care 200
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
Frames	You pay	You pay
Davis Vision Exclusive Collection frames (instead of allowance)		
• Fashion selection	\$0 copay	\$0 copay
• Designer selection	\$15 copay	\$0 copay
• Premier selection	\$40 copay	\$0 copay
Non-Collection frame allowance	Up to \$100, or up to \$150 ¹ at Visionworks, 20% discount on overage ²	Up to \$150, or up to \$200 ¹ at Visionworks, 20% discount on overage ³
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	\$0
Ultraviolet coating	\$0	\$0
Anti-reflective (AR) coating (standard/premium/ultra/ultimate)	\$40/\$55/\$69/\$85	\$35/\$48/\$60/\$85
Progressive lenses (standard/premium/ultra/ultimate)	\$65/\$105/\$140/\$175	\$0/\$40/\$90/\$125
High-index lenses (single/multi)	\$60/\$120	\$55/\$120
Transition lenses (plastic photosensitive)	\$70	\$65
Polarized lenses	\$75	\$75
Contact lenses (instead of eyeglasses)	Benefit	Benefit
Davis Vision Contact Lens Collection (instead of allowance)		
• Disposable	Not covered	8 boxes/multi-packs
• Planned replacement	Not covered	4 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 overage ³	Up to \$150, plus 15% discount on overage ³
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
Frames	\$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

Monthly premiums

Family tier	Vision Care 150	Vision Care 200
Individual	\$13.21	\$15.30
Individual + one dependent	\$26.42	\$30.60
Individual + two or more dependents	\$39.63	\$45.90

Rates are subject to change pending approval from the Pennsylvania Insurance Department.

¹ Enhanced frame allowance available at all Visionworks locations nationwide.

² Discount not available at Walmart, Sam's Club, and Costco.

³ Certain plan benefits may be enhanced to comply with health care reform law/regulations. Eligible dependent children are covered to age 26.

Independence ®

Health plan footnotes

Medical

* For these plans, visit limits are combined for office and virtual care.

- 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/Out-of-pocket maximum: 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, 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 maximum is met, 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 Blue Cross, 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 Blue Cross applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or Independence Blue Cross'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 Blue Cross's fee schedule, the amount is determined by Independence Blue Cross'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.
- 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.

Keystone HMO Proactive

- 8 For all Keystone HMO Proactive plans, the deductible is combined for Tiers 2 and 3.
- 9 For all Keystone HMO Proactive plans, the out-of-pocket maximum for Tiers 1, 2, and 3 is combined.
- 10 If a member is admitted to an in-network hospital from the emergency room, the cost-sharing for inpatient hospital care, including medical care provided by an in-network professional provider, will apply based on the tier level of the in-network hospital or in-network professional provider. If a member is admitted to an out-of-network hospital following an emergency room admission, the Tier 3 – Standard level of benefits will apply. For non-emergency care, members must use in-network providers.
- 11 For all Keystone HMO Proactive plans, all in-network retail clinics are assigned to Tier 1, with the exception of Walgreen's Health Clinic, which is assigned to Tier 3.

Prescription drugs

- 12 Our prescription drug plans are administered by an independent pharmacy benefits management (PBM) company.
- 13 No cost-sharing is required at in-network retail and mail order/home delivery pharmacies for certain preventive drugs (prescription and over-the-counter drugs with a doctor's prescription).
- 14 Out-of-network benefits apply to prescriptions filled at out-of-network pharmacies, and the member must pay the full retail price for their prescription and then file a claim for reimbursement. The member should refer to their benefit booklet to determine the out-of-network coverage for their plan.

- 15 This plan uses the Preferred Pharmacy network, with more than 57,000 pharmacies nationwide. If you have the Preferred Pharmacy network and fill a prescription at an out-of-network pharmacy, such as Walgreens, 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.
- 16 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.
- † Embedded deductible/Out-of-pocket maximum: 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

- 17 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, an independent company.
- 18 Pediatric vision benefits expire at the end of the month in which the child turns 19.
- 19 One eye exam per calendar year period.
- 20 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 in-network providers). Davis Vision Contact Lenses Collection is covered in full at in-network independent providers.
- 21 Independence Blue Cross dental plans are underwritten by QCC Insurance Company and Independence Dental Benefits are administered by Dominion Dental Services, Inc., an independent company.
- 22 Pediatric dental benefits are covered until the end of the calendar year in which the child turns 19.
- 23 One exam and one cleaning are covered every six months per calendar year.
- 24 Only medically necessary orthodontia is covered.
- 25 Virtual care from a designated virtual provider includes telemedicine, teledermatology, and telebehavioral health services offered through our virtual care provider, Teladoc Health, an independent company.
- 26 With the Adult Dental Premier plan IBX PPO 100/50/30/0 \$1,000 (MAC) and IBX Active PPO 100/80/50/50 \$1,500 (MAC), certain preventive services are not deducted from the annual benefit maximum. Please refer to your policy for additional details.
- 27 Discount is not available at Walmart, Sam's Club, and Costco.
- 28 Enhanced frame allowance is available at all Visionworks locations nationwide.
- 29 There is no deductible for orthodontia.

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 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 can choose from any of the Standard plan options on pages 19 – 42, 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 can choose from any of the Standard plan options on pages 19 – 42 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.

Family Size	Household income	
	Less than 300% FPL	More than 300% FPL
Single	\$46,949.99	\$46,950.00
Family of 2	\$63,449.99	\$63,450.00
Family of 3	\$79,949.99	\$79,950.00
Family of 4	\$96,449.99	\$96,450.00
Family of 5	\$112,949.99	\$112,950.00
Family of 6	\$129,449.99	\$129,450.00
Family of 7	\$145,949.99	\$145,950.00
Family of 8*	\$162,449.99	\$162,450.00

* For more than eight, add this amount for each additional person: \$5,500. Based on source: <https://aspe.hhs.gov/poverty-guidelines>

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.

Keystone HMO Proactive hospital tier placements

Tier 1 – Preferred \$

Pennsylvania

Bucks

Jefferson Health — Bucks Hospital
Penn Medicine — Doylestown Hospital
Prime Healthcare — Lower Bucks Hospital
Rothman Orthopaedic Specialty Hospital
St. Luke's University Health Network —
Grand View Hospital
St. Luke's University Health Network —
Quakertown Campus

Chester

Penn Medicine — Chester County Hospital
Tower Health — Phoenixville Hospital

Delaware

Main Line Health — Riddle Hospital

Lehigh

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

Montgomery

Holy Redeemer Hospital and Medical Center
Jefferson Health — Abington Hospital
Jefferson Health — Jefferson Einstein
Montgomery Hospital
Jefferson Health — Lansdale Hospital
Tower Health — Pottstown Memorial
Medical Center

Philadelphia

Jefferson Health — Frankford Hospital
Jefferson Health — Jefferson Einstein
Philadelphia Hospital
Jefferson Health — Torresdale Hospital
Prime Healthcare —
Roxborough Memorial Hospital
Temple Health — Chestnut Hill Hospital
Temple University Hospital — Jeanes Campus
Wills Eye Hospital

New Jersey

Camden

Cooper University Hospital

Warren

Hackettstown Community Hospital

Tier 2 – Enhanced \$\$

Pennsylvania

Philadelphia

Children's Hospital of Philadelphia
Shriners' Hospital for Children
Temple Health — Fox Chase Cancer Center
Tower Health — St. Christopher's Hospital for Children

New Jersey

Camden

Virtua Our Lady of Lourdes Hospital

Salem

Memorial Hospital of Salem County

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

Trinity Health — St. Mary
Medical Center

Chester

ChristianaCare — West Grove Campus
Main Line Health — Paoli Hospital

Delaware

Trinity Health —
Mercy Fitzgerald Hospital

Lancaster

Ephrata Community Hospital
Penn Medicine —
Lancaster General Hospital

Lehigh

Lehigh Valley Hospital — 17th Street
Lehigh Valley Hospital — Cedar Crest
Lehigh Valley Hospital — Muhlenberg
St. Luke's University Health Network
— Sacred Heart Campus

Montgomery

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

Philadelphia

Jefferson Health —
Methodist Hospital
Jefferson Health — Thomas Jefferson
University Hospital
Penn Medicine — Hospital of the
University of Pennsylvania
Penn Medicine —
Penn Presbyterian Medical Center
Penn Medicine —
Pennsylvania Hospital
Temple University Hospital
Temple University Hospital —
Episcopal Campus
Trinity Health — Nazareth Hospital

New Jersey

Burlington

Virtua Marlton Hospital
Virtua Memorial Hospital
Virtua Willingboro Hospital

Camden

Jefferson Health —
Cherry Hill Hospital
Jefferson Health —
Stratford Hospital
Jefferson Health —
Washington Township Hospital
Virtua Voorhees Hospital

Gloucester

Inspira Medical Center — Woodbury

Hunterdon

Hunterdon Medical Center

Mercer

Capital Health System — Fuld Campus
Capital Health System —
Hopewell Campus
Robert Wood Johnson University
Hospital at Hamilton

Salem

Inspira Medical Center — Elmer

Warren

St. Luke's University Health Network
— Warren Campus

Delaware

New Castle

ChristianaCare —
Christiana Hospital
ChristianaCare —
Wilmington Hospital
St. Francis Hospital

Maryland

Cecil

Union Hospital

Updates are made periodically to our network and provider tiering. To get the latest information, visit ibx.com/providerfinder.
Select *Keystone HMO Proactive* under Your Plan for the tiers to display.

Important plan information

Your health insurance policy may not cover all your health care expenses. Read your member handbook carefully to determine which health care services are covered.

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.

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 (preapproval/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 in-network providers.

If a member is in the second or third trimester of pregnancy at the time of the termination, the member is covered for the entire pregnancy and continued through the six-week postpartum period. 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 in-network health care providers.

The out-of-network 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 in-network 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 and ibx.com.

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 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.

Prescription drug guidelines

Our prescription drug plans are designed to provide you with safe and affordable access to covered medications. We support a number of procedures to ensure safe prescribing, including:

- **Prior authorization** — This means that you may need additional approval from your health plan. 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 prescribing practices. These rules are designed to prevent potential harm to patients and ensure that medication is being prescribed according to FDA guidelines. For example, some drugs are approved by the FDA only for individuals ages 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.

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 or call 1-866-346-2081 (TTY: 711).

Exception process

Your doctor may request coverage for a drug that is not on the formulary after a trial of covered drugs, 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 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 information

A pharmacy benefits management (PBM) company administers our prescription drug benefits and is responsible for providing a network of 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 to members at point of service. 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 call 1-855-640-3454 (TTY: 711).

What's not covered under your medical plan?

- 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, which are excluded under medical programs (however, they are covered under the prescription drug benefit)
- Adult routine eye care
- Pleoptic/orthoptic training

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 1-855-640-3454 (TTY: 711).

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English: ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-275-2583 (TTY: 711) or speak to your provider.

العربية: انتباه: إذا كنت تتحدث العربية، فيمكنك الحصول على مساعدة لغوية مجانية. كما تتوفر الوسائل والخدمات المساعدة والمناسبة مجانًا لضمان وصول المعلومات إليك بصيغة ميسرة ومناسبة. يُرجى الاتصال على الرقم 1-800-275-2583 (TTY: 711) أو يمكنك التحدث مع مقدم الرعاية الخاص بك.

বাংলা: দৃষ্টি আকর্ষণ: যদি আপনি বাংলাভাষী হন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ। অ্যাক্সেসিবল ফরম্যাটে তথ্য প্রদান করার জন্য উপযুক্ত সহায়ক উপকরণ ও পরিষেবা বিনামূল্যে উপলব্ধ। 1-800-275-2583 (TTY: 711) নম্বরে কল করুন বা আপনার প্রদানকারীর সঙ্গে যোগাযোগ করুন।

普通话: 注意: 如果您说普通话, 我们将为您免费提供语言协助服务。我们还免费提供适当的辅助工具和服务, 确保以无障碍格式传递信息。请致电 1-800-275-2583 (TTY: 711) 或咨询服务提供者。

Français: ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-275-2583 (TTY: 711) ou parlez-en à votre fournisseur.

Kreyòl Ayisyen: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis asistans pou lang ki disponib pou ou. Gen èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib ki disponib tou gratis. Rele nan 1-800-275-2583 (TTY: 711) oswa pale ak founisè w la.

ગુજરાતી: ધ્યાન આપો: જો તમે ગુજરાતી બોલો છો, તો તમારી માટે મફત ભાષા સહાયતા સેવા ઉપલબ્ધ છે. સુલભ સ્વરૂપમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનો અને સેવાઓ પણ મફતમાં ઉપલબ્ધ છે. 1-800-275-2583 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતાનો સંપર્ક કરો.

हिंदी: ध्यान दें: अगर आप हिंदी बोलते हैं, तो आपके लिए भाषा संबंधी सहायता सेवाएँ मुफ्त में उपलब्ध हैं। सुलभ फॉर्मेट में जानकारी प्रदान करने के लिए उचित सहायक सहायता और सेवाएँ भी मुफ्त में मिलती हैं। 1-800-275-2583 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italiano: ATTENZIONE: Se parli Italiano, puoi trovare disponibili servizi gratuiti di assistenza linguistica. Gratuitamente, sono inoltre disponibili ausili e servizi di supporto adeguati per fornire informazioni in formati accessibili. Chiama il numero 1-800-275-2583 (TTY: 711) oppure rivolgiti al tuo fornitore.

日本語: 注意: 日本語話者の方には、無料の言語支援サービスをご提供しています。アクセシビリティ情報を提供するための適切な補助やサービスも無料でご利用いただけます。1-800-275-2583 (TTY: 711) にお電話くださるか、または、プロバイダーにお問い合わせください。

한국어: 주의: 한국어를 구사하시는 경우 무료 언어 보조 서비스를 이용할 수 있습니다. 접근성 높은 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스 역시 무료로 이용 가능합니다. 1-800-275-2583 (TTY: 711) 에 전화하시거나 서비스 제공업체에 문의하세요.

Diné bizaad: BAA'ÁKONÍNÍZIN: Diné bizaad bee yánílti'go, t'áá jiik'eh saad bee áka'aná'awo' bee áka'anída'awo'í ná hóló. T'áadoole'é binahjii' bee adahodooníí diné bich'í' anídahazt'íí bee bika'anída'awo'í beego bee baa dahane'í baa dahwiizt'í'go hadadilyaaigíí áldó' t'áá jiik'eh hóló. Kohjii' 1-800-275-2583 (TTY: 711) hodíilnih doodago níka'análawo'í bich'í' hanidzihih.

Pennsilfaanisch-Deutsch: WICHDICH: Wann du Deutsch schwetzscht, kenne mer dich Schprooch-Hilf beigriege, unni as es dich ennich eppes koschde zellt. Mir kenne dich aa differnti Sadde Hilf beigriege, wasewwer as brauchscht fer Information griege, aa fer nix. Call 1-800-275-2583 (TTY: 711) odder schwetz mit dei Provider.

Polski: UWAGA: Jeśli jesteś osobą polskojęzyczną, pamiętaj, że oferujemy bezpłatne usługi pomocy językowej. Bezpłatnie dostępne są również odpowiednie materiały pomocnicze i usługi informacyjne w przystępnych formatach. Zadzwoń na numer 1-800-275-2583 (TTY: 711) lub porozmawiaj z dostawcą usług.

Português: ATENÇÃO: se você fala português, há serviços gratuitos de assistência linguística disponíveis. Também são disponibilizados gratuitamente para suporte e serviços auxiliares apropriados para o fornecimento de informações. Ligue para 1-800-275-2583 (TTY: 711) ou entre em contato com seu prestador.

Русский: Внимание! Если вы говорите по-русски, вам доступны бесплатные услуги переводчика. Также бесплатно предоставляются соответствующие вспомогательные услуги по предоставлению информации в доступных форматах. Звоните по телефону 1-800-275-2583 (TTY: 711) или обратитесь к своему провайдеру.

Español: ATENCIÓN: Si habla español, hay servicios gratuitos de asistencia lingüística disponibles. También hay ayudas y servicios auxiliares disponibles y sin cargo en formatos accesibles para brindarle información. Llame al 1-800-275-2583 (TTY: 711) o hable con su prestador.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available din ang naaangkop na mga auxiliary aid at serbisyo para magbigay ng impormasyon sa mga naa-access na format nang walang bayad. Tumawag sa 1-800-275-2583 (TTY: 711) o makipag-usap sa iyong provider.

తెలుగు: గమనిక: మీరు తెలుగు మాట్లాడితే, ఉచిత భాష సహాయ సేవలు మీకు అందుబాటులో ఉన్నాయి. అందుబాటులో ఉన్న ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక పరికరాలు అలాగే సేవలు కూడా ఉచితంగా లభిస్తాయి. 1-800-275-2583 (TTY: 711) నంబర్‌కు కాల్ చేయండి లేదా మీ ప్రొవైడర్‌తో మాట్లాడండి.

Українська: Увага! Якщо ви говорите українською, вам доступні безплатні послуги перекладача. Також безоплатно надаються відповідні допоміжні послуги з надання інформації в доступних форматах. Телефонуйте за номером 1-800-275-2583 (TTY: 711) або зверніться до свого провайдера.

Tiếng Việt: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng có thể nhận được các công cụ và dịch vụ hỗ trợ khác để giúp tiếp cận thông tin dễ dàng hơn, hoàn toàn miễn phí. Vui lòng gọi 1-800-275-2583 (TTY: 711) hoặc liên hệ với nhà cung cấp dịch vụ của bạn để được hỗ trợ.

Yorùbá: ÀKÍYÈSÍ: Tí ó bá nsọ Yorùbá, àwọn isẹ àtìlẹhin èdè lófẹ́ wà lárọwọ́tó rẹ. Àwọn isẹ àtìlẹhin ìrànlọwọ́ tò yẹ láti pèsè ìwífúnni ní ọ̀nà irááyèsì kíkà wà lárọwọ́tó bakanna lófẹ́. Pẹ 1-800-275-2583 (TTY: 711) tàbí kí ó bá olùpèsè rẹ sọrọ.

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 less favorably because of race, color, national origin, age, disability, or sex.

This plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance 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, in person or by mail: 1901 Market Street, Philadelphia, PA 19103, by phone: 1-888-377-3933 (TTY: 711), by fax: 215-761-0245, or by email: civilrightscordinator@1901market.com.

You can file a grievance in person or by mail, fax, or email. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at the following website: www.healthinsurancehosting.com/notices.

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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.

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. A deductible may apply only for certain services depending on the health plan.

EPO – One type of health plan. EPO stands for Exclusive Provider Organization.

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 healthcare expenses.

HMO – One type of health plan. HMO stands for Health Maintenance Organization.

In-network – The doctors, hospitals, labs, and other health care providers that have a contract with Independence Blue Cross 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 – The doctors, hospitals, labs, and other health care providers that do not have a contract with Independence Blue Cross. Certain health plans do not cover services from out-of-network providers (e.g., HMO and EPO plans) except when it's an emergency. Members who have out-of-network coverage (e.g., PPO members) typically pay more for services from out-of-network providers.

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 fully covered. Monthly premiums do not count towards your out-of-pocket maximum.

PPO – One type of health plan. PPO stands for Preferred Provider Organization.

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 receive care.

Preventive care – The care and counseling you receive to prevent health problems. Preventive care is one of the best ways to keep you and your family in good health and may detect some diseases in the early stages. Some examples of preventive care are annual checkups, flu shots, mammograms, colonoscopies, and cholesterol tests.

Primary care physician (PCP) – Another term for your family doctor. HMO health plans require you to select a PCP.

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 and most specialists, 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.

Independence ®

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.

Directly through IBX

If you don't qualify for financial assistance, you can choose from a variety of private health insurance plans offered directly through IBX. When you purchase directly from us, you have more cost-saving options and it's easier to make updates to your policy. We have licensed agents who can help you find a plan that best meets your needs.



See if you qualify

Your household income and size determine if you are eligible for a tax credit. You could pay as little as \$0/month for a high-quality health plan!

See if you qualify at ibx.com/calculator.

Pennsylvania Insurance Exchange (Pennie)

The Pennsylvania Insurance Exchange, called Pennie, is operated by the Commonwealth of Pennsylvania. When you enroll in a health plan through Pennie, financial assistance may be available if you qualify. Sometimes called a tax credit or subsidy, financial assistance helps those who qualify pay for health insurance costs.

You may qualify for:

- Lower monthly premiums¹
- Lower monthly premiums and lower out-of-pocket costs when you receive care²

Who needs coverage?	What is the income for those covered under the health plan? (income % of Federal Poverty Level)			
	138 – 149%	150 – 199%	200 – 249%	250 – 400%
Single	\$21,597.00 – \$23,474.99	\$23,475.00 – \$31,299.99	\$31,300.00 – \$39,124.99	\$39,125.00 – \$62,600.00
Family of 2	\$29,187.00 – \$31,724.99	\$31,725.00 – \$42,299.99	\$42,300.00 – \$52,874.99	\$52,875.00 – \$84,600.00
Family of 3	\$36,777.00 – \$39,974.99	\$39,975.00 – \$53,299.99	\$53,300.00 – \$66,624.99	\$66,625.00 – \$106,600.00
Family of 4	\$44,367.00 – \$48,224.99	\$48,225.00 – \$64,299.99	\$64,300.00 – \$80,374.99	\$80,375.00 – \$128,600.00
Family of 5	\$51,957.00 – \$56,474.99	\$56,475.00 – \$75,299.99	\$75,300.00 – \$94,124.99	\$94,125.00 – \$150,600.00
Family of 6	\$59,547.00 – \$64,724.99	\$64,725.00 – \$86,299.99	\$86,300.00 – \$107,874.99	\$107,875.00 – \$172,600.00
Family of 7	\$67,137.00 – \$72,974.99	\$72,975.00 – \$97,299.99	\$97,300.00 – \$121,624.99	\$121,625.00 – \$194,600.00
Family of 8 ³	\$74,727.00 – \$81,224.99	\$81,225.00 – \$108,299.99	\$108,300.00 – \$135,374.99	\$135,375.00 – \$216,600.00
You may be eligible for...				
Type	Premium tax credit and cost-share 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	Pages 60 – 66	Pages 53 – 59	Pages 46 – 52	Pages 19 – 42

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

² 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: \$5,500. Source: ASPE HHS, <https://aspe.hhs.gov/poverty-guidelines>

International health plans from Blue Cross Global SolutionsSM



Before you travel outside the U.S., it's important to have a health plan that can go the distance with you. Here's an easy way to think of it: If you need a passport, you need an international health plan.

That's where Blue Cross Global Solutions health plans come in. You'll get peace of mind knowing you have health insurance that's specially designed for worldwide travel.

- Flexible options that may include coverage for pre-existing conditions
- Access to quality doctors and hospitals in 190 countries
- Telemedicine services for non-emergency care at no additional cost to you
- Convenient, self-service mobile app and member site to help you locate doctors and hospitals, translate medicines, request payment to providers, and more
- Coverage for medical evacuation, if needed
- 24/7/365 support



Get more information
and an instant quote

Visit ibx.com/global

Call **1-855-481-6647**
(TTY: 711)



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Independence Blue Cross offers products through its subsidiaries Independence Assurance Company, Independence Hospital Indemnity Plan, Keystone Health Plan East, and QCC Insurance Company — independent licensees of the Blue Cross and Blue Shield Association.

