

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Independence  **Keystone HMO Silver Proactive Select**

 **The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.**
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ibx.com/IndBooklet or by calling 1-800-ASK-BLUE (TTY:711). For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Tier 1: \$0 person / \$0 family; For Tier 2 & 3: \$6,000 person / \$12,000 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible?	Yes. Preventive care , Primary care services, Specialist services and Emergency room services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. For prescription drug services INN \$300 person / \$600 family. OON \$300 person / \$600 family. For pediatric dental services INN \$50 person. There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For Participating providers \$8,650 person / \$17,300 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers .	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2 or Tier 3. You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .



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

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40/Visit.	\$60/Visit. Deductible does not apply.	\$70/Visit. Deductible does not apply.	Not covered.	Telemedicine (from designated telemedicine provider , www.ibx.com/findcarenow): No charge. Additional copayments may apply when you receive other services at your provider's office.
	Specialist visit	\$80/Visit.	\$120/Visit. Deductible does not apply.	\$140/Visit. Deductible does not apply.	Not covered.	PCP referral required. Additional copayments may apply when you receive other services at your provider's office.
	Preventive care/ screening/ immunization	No charge.	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered.	Age and frequency schedules may apply. For colorectal cancer screening , your cost is \$750/Procedure(s) at a non-preventive plus provider . You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-Ray: \$150/Visit. Blood Work: No charge.	X-Ray: \$150/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	X-Ray: \$150/Visit. Deductible does not apply. Blood Work: No charge. Deductible does not apply.	Not covered.	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	\$300/Scan.	\$300/Scan. Deductible does not apply.	\$300/Scan. Deductible does not apply.	Not covered.	Precertification required for certain services. *See section MC - Using the HMO system.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/ffm/formulary5v .	Generic Drugs	Retail/Mail Order (1-30 days supply) \$20/Fill. Mail Order (31-90 days supply) \$40/Fill.	Retail/Mail Order (1-30 days supply) \$20/Fill. Mail Order (31-90 days supply) \$40/Fill.	Retail/Mail Order (1-30 days supply) \$20/Fill. Mail Order (31-90 days supply) \$40/Fill.	Not covered. Retail (1-30 days supply) 30% reimbursement.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) prescription drug . Low-Cost Generics will be available at a reduced cost. This plan has a Preferred Pharmacy Network which excludes Walgreens. Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid. Mandatory Generic.
	Preferred Brand	Retail/Mail Order (1-30 days supply) \$100/Fill. Mail Order (31-90 days supply) \$200/Fill.	Retail/Mail Order (1-30 days supply) \$100/Fill. Mail Order (31-90 days supply) \$200/Fill.	Retail/Mail Order (1-30 days supply) \$100/Fill. Mail Order (31-90 days supply) \$200/Fill.	Not covered. Retail (1-30 days supply) 30% reimbursement.	Prior authorization age and quantity limits for some drugs; days supply limits on retail & mail order. *See section(s) prescription drug . Low-Cost Generics will be available at a reduced cost. This plan has a Preferred Pharmacy Network which excludes Walgreens. Up to a 90-day supply of drugs to treat chronic conditions available at Rite Aid. Mandatory Generic.
	Non Preferred Drugs	Retail/Mail Order (1-30 days supply) 50% coinsurance (\$500 max/fill). Mail Order (31-90 days supply) 50% coinsurance (\$1,000 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance (\$500 max/fill). Mail Order (31-90 days supply) 50% coinsurance (\$1,000 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance (\$500 max/fill). Mail Order (31-90 days supply) 50% coinsurance (\$1,000 max/fill).	Retail/Mail Order (1-30 days supply) 50% coinsurance (\$500 max/fill). Mail Order (31-90 days supply) 50% coinsurance (\$1,000 max/fill).	Not covered. Retail (1-30 days supply) 30% reimbursement.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out-of-Network Provider (You will pay the most)	
	Specialty Drugs	Retail (1-30 days supply) 50% coinsurance (\$1,000 max/fill).	Retail (1-30 days supply) 50% coinsurance (\$1,000 max/fill).	Retail (1-30 days supply) 50% coinsurance (\$1,000 max/fill).	Not covered.	This applies to self-administered specialty drugs covered under the prescription drug plan . Limited to a maximum 30 days supply. Prior authorization and/or additional dispensing limits may apply. Other specialty injectables and infusion therapy drugs may be covered under your medical benefits. *See section(s) prescription drug .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250/Visit.	Subject to deductible and \$750/Visit.	Subject to deductible and \$1,250/Visit.	Not covered.	Precertification may be required. *See section MC - Using the HMO system.
	Physician/surgeon fees	No charge.	5% coinsurance .	10% coinsurance .	Not covered.	
If you need immediate medical attention	Emergency room care	\$600/Visit.	\$600/Visit. Deductible does not apply.	\$600/Visit. Deductible does not apply.	Covered at In-Network level.	None
	Emergency medical transportation	\$200/Transport.	\$200/Transport. Deductible does not apply.	\$200/Transport. Deductible does not apply.	Covered at In-Network level.	
	Urgent care	\$80/Visit.	\$80/Visit. Deductible does not apply.	\$80/Visit. Deductible does not apply.	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600/Day. Max of 5 Copayment (s)/ Admission.	Subject to deductible and \$900/Day. Max of 5 Copayment (s)/ Admission.	Subject to deductible and \$1,300/Day. Max of 5 Copayment (s)/ Admission.	Not covered.	Precertification required.
	Physician/surgeon fees	No charge.	5% coinsurance .	10% coinsurance .	Not covered.	

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$80/Visit.	\$80/Visit. Deductible does not apply.	\$80/Visit. Deductible does not apply.	Not covered.	Precertification required.
	Inpatient services	\$600/Day. Max of 5 Copayment(s) / Admission.	\$600/Day. Max of 5 Copayment(s) / Admission. Deductible does not apply.	\$600/Day. Max of 5 Copayment(s) / Admission. Deductible does not apply.	Not covered.	
If you are pregnant	Office visits	\$80/Visit.	\$120/Visit. Deductible does not apply.	\$140/Visit. Deductible does not apply.	Not covered.	Office visit cost share applies to the first OB visit only. Depending on the type of services, additional copayments or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	No charge.	5% coinsurance .	10% coinsurance .	Not covered.	
	Childbirth/delivery facility services	\$600/Day. Max of 5 Copayment(s) / Admission.	Subject to deductible and \$900/Day. Max of 5 Copayment(s) / Admission.	Subject to deductible and \$1,300/Day. Max of 5 Copayment(s) / Admission.	Not covered.	
If you need help recovering or have other special health needs	Home health care	No charge.	5% coinsurance .	10% coinsurance .	Not covered.	Precertification required. 60 Visit(s)/ Calendar Year.
	Rehabilitation services	\$80/Visit.	\$80/Visit. Deductible does not apply.	\$80/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical and Occupational Therapies: 30 visits combined/ Calendar Year. Speech Therapy: 30 visits/ Calendar Year.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		In-Network Tier 1 - Preferred (You will pay the least)	In-Network Tier 2 - Enhanced	In-Network Tier 3 - Standard	Out-of-Network Provider (You will pay the most)	
	Habilitation services	\$80/Visit.	\$80/Visit. Deductible does not apply.	\$80/Visit. Deductible does not apply.	Not covered.	PCP referral required. Physical and Occupational Therapies: 30 visits combined/Calendar Year. Speech Therapy: 30 visits/Calendar Year. Visit limits do not apply to services that are prescribed for Mental Health Care and Serious Mental Illness Health Care, and Treatment of Alcohol or Drug Abuse and Dependency.
	Skilled nursing care	\$300/Day. Max of 5 Copayment(s)/Admission .	\$300/Day. Max of 5 Copayment(s)/Admission . Deductible does not apply.	\$300/Day. Max of 5 Copayment(s)/Admission . Deductible does not apply.	Not covered.	Precertification required. 120 Day(s)/Calendar Year.
	Durable medical equipment	50% coinsurance .	50% coinsurance . Deductible does not apply.	50% coinsurance . Deductible does not apply.	Not covered.	Precertification required for selected items. *See section MC - Using the HMO system.
	Hospice services	No charge.	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Not covered.	Precertification required.
If your child needs dental or eye care	Children's eye exam	No charge.	No charge.	No charge.	Not covered.	Once every Calendar Year.
	Children's glasses	No charge.	No charge.	No charge.	Not covered.	1 pair of glasses (lenses/frames) or contacts per Calendar Year.
	Children's dental check-up	No charge.	No charge.	No charge.	Not covered.	1 Exam(s)/Every 6 Months.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
• Acupuncture	• Hearing aids	• Routine eye care (Adult)
• Bariatric surgery	• Long-term care	• Routine foot care
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic care	• Infertility treatment (only covered for artificial insemination)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for these agencies is: Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>. To contact the [plan](#), call 1-800-ASK-BLUE (TTY: 711), or the contact information for those agencies is: Pennsylvania Insurance Department - 1-877-881-6388 - <http://www.insurance.pa.gov/Consumers>. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the Pennsylvania [Health Insurance Marketplace](#), visit www.Pennie.gov or call 1-844-844-8040.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Pennsylvania Insurance Department - 1-877-881-6388 - <http://www.insurance.pa.gov/Consumers>.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Not Applicable.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

*For more information about limitations and exceptions, see plan or policy document at www.ibx.com/IndBooklet.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$600
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
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Deductibles*	\$0
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Copayments	\$1,500
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Coinsurance	\$0
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<i>What isn't covered</i>	
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Limits or exclusions	\$20
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The total Peg would pay is	\$1,520
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Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$600
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
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Deductibles*	\$300
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Copayments	\$2,400
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Coinsurance	\$0
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<i>What isn't covered</i>	
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Limits or exclusions	\$20
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The total Joe would pay is	\$2,720
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$80
■ Hospital (facility) copayment	\$600
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
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Deductibles*	\$0
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Copayments	\$1,100
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Coinsurance	\$40
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<i>What isn't covered</i>	
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Limits or exclusions	\$0
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The total Mia would pay is	\$1,140
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Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-ASK-BLUE (TTY:711)

Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See 'Are there other [deductibles](#) for specific services?' row above.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

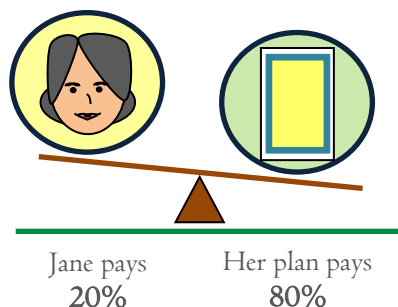
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Cost Sharing

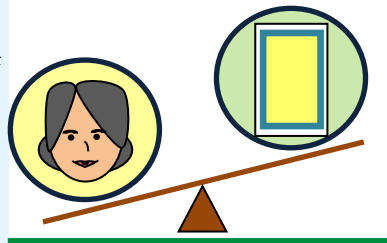
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

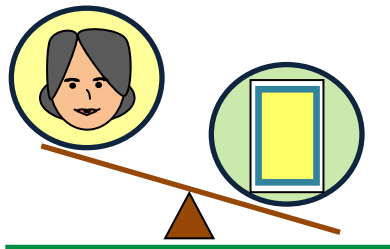
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Jane pays
0%

Her plan pays
100%

(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as “skilled care services,” which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000

January 1st
Beginning of Coverage Period

December 31st
End of Coverage Period



Jane hasn't reached her \$1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0



Jane reaches her \$1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid \$1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: \$125

Jane pays: 20% of \$125 = \$25

Her plan pays: 80% of \$125 = \$100



Jane reaches her \$5,000 out-of-pocket limit

Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: \$125

Jane pays: \$0

Her plan pays: \$125

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Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Persian (Farsi):

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

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

Urdu:

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

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

Discrimination is Against the Law

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

This Plan provides:

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

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

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