Independence

# 2018 Blue Solutions®

## Comprehensive, affordable coverage for small employers

Health | Prescription Drug | Vision | Dental | Well-being | Additional Workplace Benefits

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# We're making health care work better for you

With our Blue Solutions® health plans, Independence Blue Cross (Independence) provides your employees and their families with comprehensive, affordable coverage and resources to help them maximize their benefits and live healthier. We added new health plans and made other enhancements for 2018.

## Two new health plans give you more choice

### HMO Platinum Preferred $30/$60/$400

This competitively priced plan offers high-level benefits with low out-of-pocket costs. See page 19. Features of our HMO Platinum plans:

- Give members predictability with fixed out-of-pocket costs and no deductible.
- Members must choose a primary care physician to coordinate care, which helps lower costs.
- No out-of-network benefits, except emergency and urgent care.

### EPO Silver HSA-O $3,000/80%

This plan lets members access our PPO network at a lower premium and pairs with an HSA for additional savings. See page 39. Features of our EPO plan:

- Combines the flexibility of a PPO and the cost savings of an HMO.
- Members can choose any in-network provider and don't need to pick a PCP or get referrals.
- In-network benefits covered out of area through the BlueCard® PPO. No out-of-network benefits, except emergency and urgent care.

## Enhanced PT/OT and radiology benefit

Non-HSA-qualified PPO plans have an enhanced benefit to help members lower out-of-pocket costs for physical and occupational therapy and radiology, based on location. See page 5.

## Increase retention with the College Tuition Benefit®

Employees can earn Tuition Rewards® points to help eligible family members pay for their undergraduate education. See page 53.

## New tools help empower member well-being

Achieve with Independence tools and programs motivate members to take an active role in their health. See page 12.

## More cost-effective prescription drug formulary

All plans use the new Value Formulary to drive more cost-effective prescription drug utilization. See page 8.

# Wide range of health plans gives you coverage and cost flexibility

We have a variety of health plans designed to help you lower costs and help members get access to high-quality, affordable care. You also have the choice to add benefits like adult dental coverage and supplemental insurance to complement your medical coverage.

**FOR EMPLOYERS**

- Plans at every price point
- Cost-sharing flexibility
- Employee satisfaction & retention

**FOR MEMBERS**

- Access to a wide provider network
- Affordable cost-sharing
- More choice and control

## Choose with confidence

Blue Solutions plans cover required essential health benefits and are arranged by metallic levels so it's easier to compare coverage and cost.

### Blue Solutions plans include:

Essential health benefits

Pediatric and adult vision benefits

Pediatric dental benefits

# Mix it up with a variety of plans that meet your needs and budget

No matter what size your business is, you can choose up to three plans to fit your budget and ensure employees and their families are covered — even if they live outside of our service area. You decide how much flexibility covered members have to choose providers and how much they'll pay when they need care.

| | Personal Choice® PPO | Personal Choice EPO | Keystone Direct POS | Keystone HMO |
|---|---|---|---|---|
| Access to more than 60,000 doctors | X | X | X | X |
| Out-of-network benefits | X | | X | |
| Select a PCP | | | X | X |
| No specialist referrals needed for the highest level of benefits | X | X | X[1] | |
| In-network benefits nationwide through BlueCard® PPO | X | X | | |
| Away from Home Care® for members temporarily living outside the coverage area | | | X | X |
| Emergency and urgent care access worldwide | X | X | X | X |

1. Members with a Direct POS plan need a referral from their PCP for certain services: Routine X-rays, spinal manipulations, and physical/occupational therapy. For lab work, members should use the designated site selected by their PCP for the lowest out-of-pocket costs.

## Complete your package with additional workplace benefits

### Protect employees' health

#### Adult dental coverage

- 3 PPO plans to choose from
- 1 HMO rider

### Protect employees' wealth

#### Supplemental insurance

- Life insurance
- Disability insurance
- Accident, critical illness, and cancer insurance
- Hospital indemnity insurance

### Give employees peace of mind

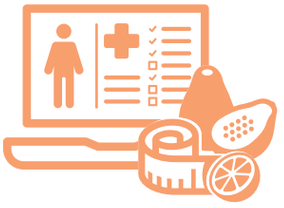
#### International health insurance

- Health plans for single trips, multiple trips, and expats

#### College tuition benefit

- Employees can earn points to help eligible family members pay for tuition at 375+ participating private colleges and universities

# Built-in benefits empower members to save on care



All Blue Solutions plans give members the choice to save money — in some cases hundreds of dollars — based on where they go for care. Refer to the plan charts beginning on page 16 for cost-sharing amounts.

## Services members can save on:

### Preventive Plus — Preventive colonoscopy[1]

- Members pay $0 for a preventive colonoscopy by choosing Preventive Plus providers and GI professionals that are not hospital based[2]
- Out-of-pocket costs can be up to $750 by choosing non-Preventive Plus providers and professionals
- Preventive Plus benefit included in all plans

### Outpatient lab services

- Members pay their plan's designated cost-sharing amount, which is higher, at a hospital-based lab
- For HMO and Direct POS plans, in-network lab services are covered at 100 percent when members use their PCP's designated lab site
- All non-HSA and non-HRA plans offer $0 cost-sharing when members use a freestanding in-network lab

### Outpatient surgery

- Members pay less at in-network ambulatory surgical centers (ASCs)
- Common outpatient surgical procedures performed at ASCs include tonsil removal, hernia repairs, and cataract surgeries
- Benefit included in most non-HSA-qualified plans

### NEW! Physical/occupational therapy and routine/complex radiology

- Members pay less at office-based providers or freestanding sites
- Member cost-sharing is higher at hospital-based sites
- Benefit included in non-HSA-qualified PPO plans

1. Age and frequency guidelines apply to preventive care, such as colonoscopies.
2. The Preventive Plus benefit does not apply to members who reside or travel outside our service area and access care through the BlueCard® Program or the Away From Home Care® Guest Membership Program. For these members, a preventive colonoscopy to screen for colorectal cancer will be covered at no cost when they use an in-network provider. However, if they choose to visit an out-of-network provider, cost-sharing for their plan's out-of-network benefit applies, and their out-of-pocket costs may be significantly higher.

# Tiered network plans offer more choice and savings


## Our Keystone HMO Proactive tiered network plans give members access to the full Keystone network at a lower premium and the choice to lower out-of-pocket costs when they need care.

Providers are grouped into three tiers based on cost and quality measures. Members must choose a PCP to coordinate their care and refer them to specialists. They save the most by choosing providers in **Tier 1 — Preferred** but are always free to choose providers in any of the three tiers.

### These services have the same cost-sharing across all tiers:

- Preventive care
- Emergency room
- Urgent care
- Outpatient labs
- Prescription drugs
- Pediatric dental and vision
- Mental health services
- Physical and occupational therapy
- Routine radiology
- Spinal manipulations


## Savings on specialty care with Keystone HMO Proactive plans

Hospitals designated as a Blue Distinction Center+ (BDC+) are recognized for their expertise and efficiency in delivering specialty care, such as knee and hip replacements. Our Keystone HMO Proactive plans give members the option to save on specialty care by choosing a BDC+ hospital in Tier 1 — Preferred, while being confident that it:

- Has extensive experience in one or more categories of specialty care
- Meets rigorous quality standards
- Consistently demonstrates positive care results

**Keystone HMO Proactive hospital tier placements and BDC+ hospitals**

Blue Distinction® Center+ Specialties

- Cardiac care
- Spine surgery
- Knee and hip replacement
- Maternity care

Tier placements are reviewed annually and are subject to change. Visit **ibx.com/proactivehospitals** for the current list.

## Tier 1 — Preferred ($)

### Pennsylvania

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

**Chester**
- Brandywine Hospital
- Chester County Hospital
- Jennersville Regional Hospital
- Phoenixville Hospital

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

**Lehigh**
- St. Luke's Health Network — Allentown Campus
- St. Luke's Health Network — Bethlehem Campus

**Montgomery**
- Abington Memorial Hospital
- Albert Einstein Medical Center – Montgomery Campus
- Holy Redeemer Hospital and Medical Center
- Lansdale Hospital
- Pottstown Memorial Medical Center
- Suburban Community Hospital

**Philadelphia**
- Albert Einstein Medical Center
- Albert Einstein Medical Center — Germantown Campus
- Aria Health — Frankford Campus
- Aria Health — Torresdale Campus
- Chestnut Hill Hospital
- Hahnemann University Hospital
- Jeanes Hospital
- Roxborough Memorial Hospital
- Wills Eye Hospital

### New Jersey

**Burlington**
- Deborah Heart & Lung Center
- Lourdes Medical Center of Burlington County

**Camden**
- Cooper Hospital University Medical Center

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

**Salem**
- Memorial Hospital of Salem County

**Warren**
- Hackettstown Community Hospital

## Tier 2 - Enhanced ($$)

### Pennsylvania

**Philadelphia**
- Children's Hospital of Philadelphia
- Fox Chase Cancer Center
- St. Christopher's Hospital for Children
- Shriner's Hospital for Children

### New Jersey

**Camden**
- Our Lady of Lourdes Medical Center

**Gloucester**
- Inspira Medical Center — Woodbury

### Delaware

**New Castle**
- A.I. DuPont Hospital for Children

## Tier 3 – Standard ($$$)

### Pennsylvania

**Berks**
- Reading Hospital and Medical Center
- St. Joseph Medical Center

**Bucks**
- St. Mary Medical Center

**Chester**
- Main Line Health — Paoli Hospital

**Delaware**
- Main Line Health — Riddle Hospital

**Lancaster**
- Ephrata Community Hospital
- Heart of Lancaster Regional Medical Center
- Lancaster General Hospital
- Lancaster Regional Medical Center

**Lehigh**
- Lehigh Valley Hospital
- Lehigh Valley Hospital — Muhlenberg
- Sacred Heart Hospital

**Montgomery**
- Main Line Health — Bryn Mawr Hospital
- Main Line Health — Lankenau Medical Center

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

### New Jersey

**Burlington**
- Virtua Memorial Hospital
- Virtua Marlton Hospital

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

**Hunterdon**
- Hunterdon Medical Center

**Mercer**
- Capital Health System — Fuld Campus
- Capital Health System — Hopewell Campus

**Salem**
- Inspira Medical Center — Elmer

**Warren**
- St. Luke's Health Network — Warren Hospital

### Delaware

**New Castle**
- Christiana Care Health System — Christiana Hospital
- Christiana Care Health System — Wilmington Hospital
- St. Francis Hospital

### Maryland

**Cecil**
- Union Hospital

# Comprehensive coverage helps keep members healthier

With coverage included for prescription drugs, adult and pediatric vision, and pediatric dental, Blue Solutions plans help members better manage their total health — which in turn helps reduce your overall health care costs.

## Prescription drug benefits encourage safe, effective, and affordable use

Our prescription drug benefits, administered by FutureScripts®, provide members with access to covered medications, while helping to manage costs for you and members alike.

NEW!

### Value Formulary

- Our plans use this new comprehensive list of generic, brand, and specialty drugs
- Drives more cost-effective utilization
- Drugs may not be covered when there are good alternatives used to treat the same condition at a lower cost

### Preferred Pharmacy Network

- Feature of our Silver (excludes EPO) and Bronze plans and Keystone HMO Proactive plans
- Includes more than 50,000 pharmacies, including CVS, Walmart, Target, and many independent pharmacies
- Does not include Rite Aid and Walgreens pharmacies*

### Low-Cost Generic Copay

- Included in Keystone HMO Proactive plans
- Allows members to pay even less than standard generic cost-sharing for some generic drugs
- Members pay $4 for certain generics at participating retail pharmacies

### Specialty Drug Cost-Share

- Specialty drugs treat complex or chronic diseases, such as rheumatoid arthritis, hepatitis C, and certain cancers
- Require special handling, administration, and monitoring
- Designated cost-share helps manage the increasingly high costs for specialty drugs, which are typically used by a small number of members

**EASY TO USE ONLINE TOOLS**

Find a network pharmacy, estimate drug costs, review claims, and submit mail-order requests at ibxpress.com

**VALUE FORMULARY**

Encourages members to consider generic drugs and lower cost brand medications

**MAIL ORDER CONVENIENCE**

Free home delivery for medications members take regularly; some may get a 90-day supply for the cost of a 60-day supply

**SPECIALTY DRUG SAVINGS WITH BRIOVA Rx®**

Members receive support from pharmacists and nurses experienced in treating rare, complex, and chronic diseases

**68K+ PHARMACIES NATIONWIDE**

All plans offer access to an extensive network of retail and independent pharmacies*

* The Preferred Pharmacy network includes more than 50,000 pharmacies. With plans that use the Preferred Pharmacy network, filling a prescription at a non-participating pharmacy such as Rite Aid or Walgreens is considered out of network, and members must pay the total cost up front. They may be able to get reimbursed for part of this cost, but they will need to submit a claim and reimbursement will be at a lower rate.

## Vision benefits for adults and children

Regular eye exams do more than just protect a person's sight — they can help detect more serious medical conditions like diabetes, hypertension, and heart disease.

- All plans include vision benefits, administered by Davis Vision®, for enrolled adults and children
- One routine in-network eye exam is covered in full per calendar year
- Adults get an extra $50 to spend toward the purchase of frames at Visionworks

### Easy-to-Use Online Tools

Find a Davis Vision provider, view frame options, and review coverage at ibxpress.com

### Frame & Lens Coverage

Full coverage or low copay from the Davis Vision Exclusive Collection. One-year frame and lens warranty from Davis Vision providers

### Replacement Contact Lenses

Low prices and same-day shipping* for replacement lenses and solution to most locations from davisvisioncontacts.com

### Vision Correction Discounts

Up to 25% off participating provider's usual and customary fees or 5% off advertised specials

### 60,000+ Points of Access

Extensive network of providers and retailers, including Visionworks locations

* Shipping is available in the United States, including Hawaii and Alaska. Shipping outside the United States, including Puerto Rico, is currently not available.

## Pediatric dental benefits help kids form healthy habits

All plans include in-network dental benefits[1] for enrolled members up to age 19 — one of the ten essential health benefits required by law.

### Personal Choice® PPO pediatric dental coverage (included in all PPO plans)

- In-network dental exams and cleanings covered in full once every six months
- Freedom to choose any provider in the nationwide Concordia Advantage network
- No referrals required

### Keystone Health Plan East DHMO pediatric dental coverage (included in all HMO and DPOS plans)

- In-network dental exams and cleanings covered in full once every six months
- Must choose a Primary Dental Office (PDO) from the Keystone DHMO network
- Referrals required from PDO for specialist services

**Make sure the whole family is covered**

Add affordable dental coverage for adults age 19 and older to your medical benefits.

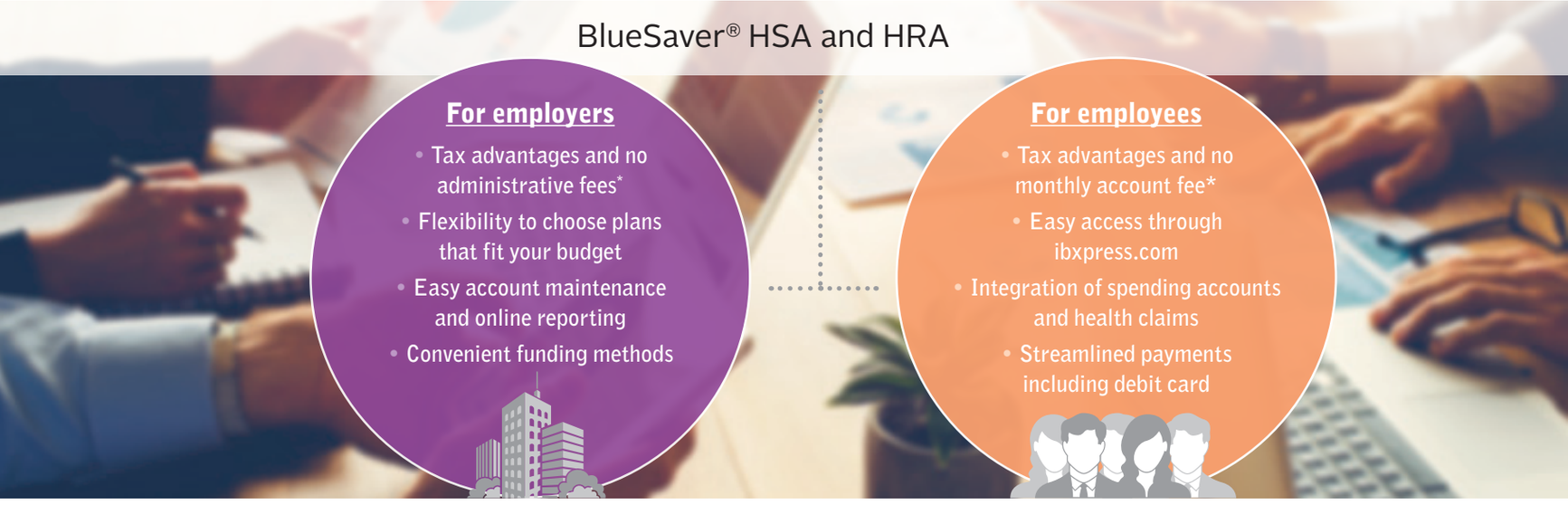
See page 49 for our adult dental coverage options.

1. Pediatric dental benefits are in-network only and include basic and major services, in addition to medically necessary orthodontia. All coinsurance, deductibles, and copayments for pediatric dental services contribute to the plan's out-of-pocket maximum.

# Spending accounts are a smart addition to your health plans

Spending accounts give employees more control over planning and paying for qualified medical expenses to help them maximize their health care dollars. Plus, they help you and employees save on taxes.

## BlueSaver® HSA and HRA




### Choose the tax-advantaged health spending account that works best for you

| | HSA | HRA |
|---|---|---|
| Why employers offer | Most flexible option, allows employers to choose lower premium plans with higher deductibles, while giving employees a way to save for qualified health care expenses | Employer owns the account, contributes tax-advantaged funds only when claims are paid, and can limit eligible expenses |
| Compatible with | HSA-qualified plans | Eligible HRA plans |
| Who owns the account | Employee | Employer |
| Who funds the account[1] | Employer and/or employee | Employer |
| Who establishes contribution rules | IRS | Independence and employer |
| Helps pay for[2] | Qualified medical expenses | Qualified medical expenses as determined by employer and federal regulations |
| Funds carry over | Yes | Employer option |
| Portable | Yes | No |

* Some banking fees may apply.

1. Refer to page 47 for information about spending account funding requirements.
2. Refer to IRS Publication 502 for a complete list of qualified medical and dental expenses. If account funds are used for non-qualified medical expenses, they are subject to the current tax rate and may be subject to a 20 percent penalty.

Independence does not provide legal or tax advice. Consult your legal and/or tax advisor for rules regarding the tax advantages of spending accounts.

# Helping members improve their overall health and well-being

We're committed to making it as easy as possible for members to understand their benefits and get the most out of them. Whether they're trying to find a doctor, get healthier, or make an important decision, members can Achieve with Independence.

## Achieve Well-being

- Engaging, online tools that make it easy for members to achieve their well-being goals
- Personalized action plan includes ongoing activities and reminders
- Ability to sync with fitness apps and devices for progress and biometrics
- Reimbursements for gym workouts, weight management, and tobacco cessation programs

## Achieve Better Health

- 24/7 access to a registered nurse Health Coach who can answer questions on any health topic
- Resources and support for members with chronic conditions
- Case managers to help members with serious illnesses or conditions
- Maternity program to support pregnant members

## Discounts and savings

- Nutrition counseling visits at no cost
- Online newsletter with healthy recipes and coupons[1]
- Money-saving discounts on health and well-being products and services[1]
- Deals on amusement parks, hotels, shopping, movie tickets, sporting events, and museums[1]

## Benefits tools and information

- Benefits summaries, booklets, EOBs, referrals, claims, and spending — all accessible at ibxpress.com and on our mobile app
- Find a doctor tool and treatment cost estimator
- Prescription drug finder and pricing tools
- Ask IBX tool helps answer member questions

1. Value-added programs are not benefits and are subject to change.

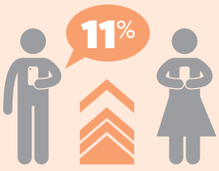
## Driving higher member engagement for powerful results

To ensure members are taking advantage of benefits, tools, and programs, we use IBX Wire® text messages and emails to:

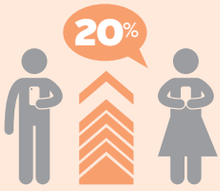
- Remind members to get tests and screenings
- Drive members to lower-cost options
- Explain how benefits work
- Encourage healthy behavior

When comparing the behavior of members who are engaged in these messaging channels to our unengaged members, we see some very compelling statistics.[2]

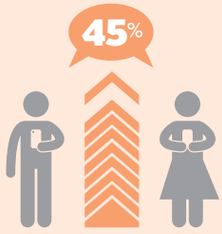

## Digitally engaged members are making healthy choices




11 percent increase in compliance with necessary tests and screenings




20 percent increase in switch rate from brand to generic drugs




45 percent more calls to Health Coaches

2. Results based on analysis of campaign engagement comparing members who are digitally engaged to those who are not.

# Making health care coverage easier to manage

## ibxpress.com account management

Our secure employer website allows you to administer your health benefits efficiently.

### Manage your account

- Add or delete an employee
- Change employee or dependent information
- View an employee's coverage history
- View account transaction history
- Administer spending accounts quickly and easily

### Pay with eBill

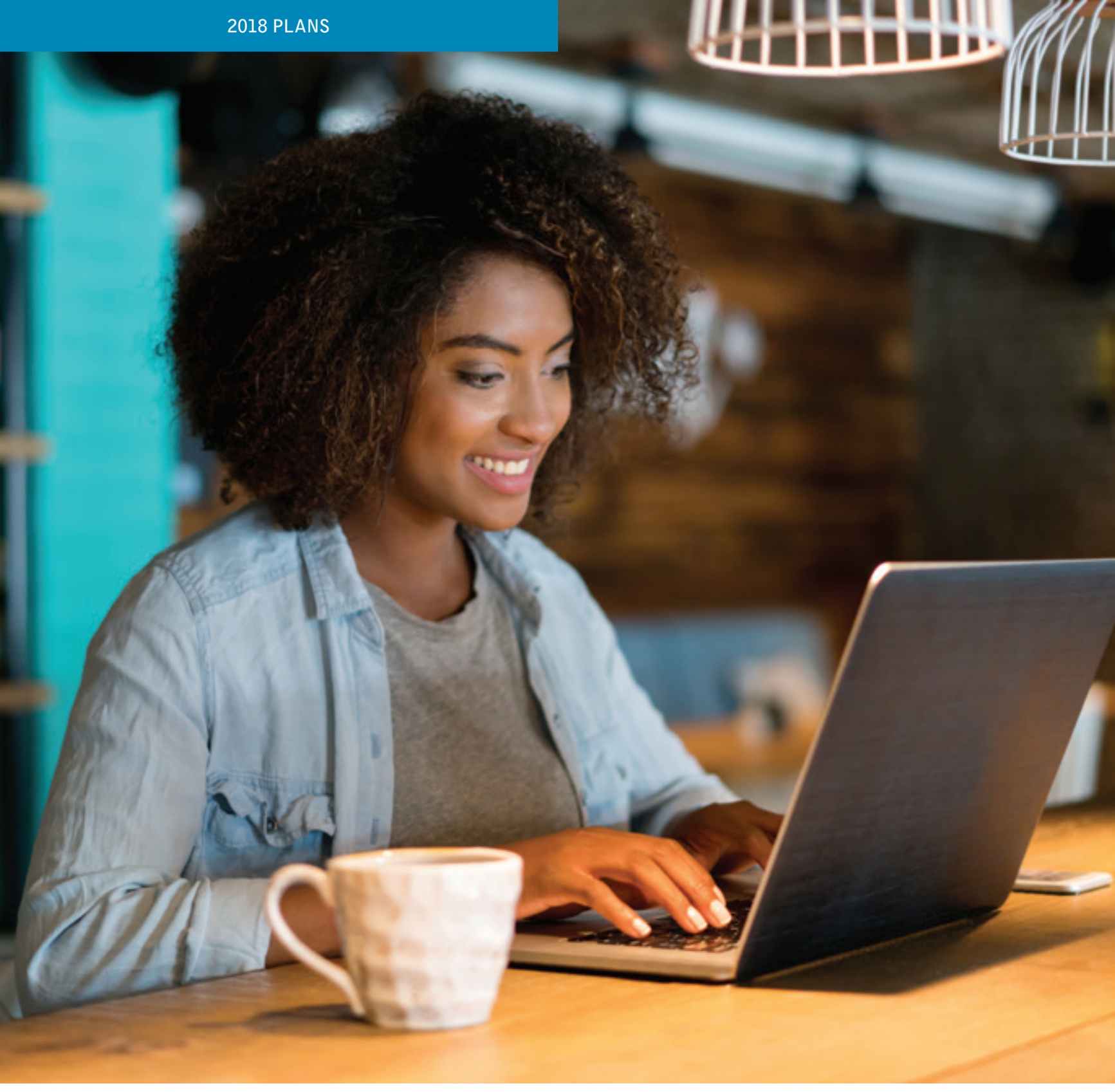
- Pay invoices through eBill
- View current and prior invoices
- Get billing reminders
- Review billing and invoice payment history

### Promote a culture of well-being with self-service tools

Our Worksite Well-being site helps promote a culture of well-being among employees with free online resources.

- Well-being campaign calendars
- Fall and spring well-being events
- Monthly well-being newsletter for members

Create a healthier workforce today: wellbeing.ibx.com



# 2018 Benefits at a Glance

# Choose from plan options at various price points in all metallic levels

## Preferred: Copay Health Plans

### Give employees the predictability of fixed out-of-pocket costs

- No deductible for in-network services
- Platinum and Gold options provide lower out-of-pocket costs
- PPO plans for more flexibility; HMO and DPOS plans for affordability

## Classic: Coinsurance/Deductible Health Plans

### Give employees more control over their health care choices

- Copays for doctor office visits
- Coinsurance on other services, including inpatient hospital admissions and outpatient surgical procedures
- PPO, HMO, and DPOS plans available

## Secure: Copay/Deductible Plans

### Balance lower premiums with predictable out-of-pocket costs

- Copays for the most commonly used services
- Members save even more by visiting designated or freestanding sites instead of hospital-based sites for care
- PPO and HMO plans available

## Essential: High-Deductible Health Plans with Integrated Pharmacy Deductible*

### Offer employees more control of their health care dollars

- Prescription drug expenses accumulate toward overall plan deductible
- Copays for doctor office visits
- Encourage smarter, more informed health care choices
- HMO and DPOS plans available

*These are not HSA or HRA plans.

| Platinum health plans | Personal Choice PPO Platinum Preferred[2] $10/$20/$150 | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[7] |
| Deductible, individual/family | $0 | $2,000/$4,000 |
| Coinsurance | 0% | 50% |
| Out-of-pocket maximum, individual/family includes: | $3,500/$7,000 coinsurance and copays | $5,000/$10,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $10 | 50% after ded |
| Specialist office visit | $20 | 50% after ded |
| Telemedicine† | $40 | Not covered |
| Urgent care | $70 | 50% after ded |
| Spinal manipulations (20 visits per year) | $20[9] | 50% after ded[9] |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $20/$50[9] | 50% after ded/50% after ded[9] |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | $150 per day[11] | 50% after ded |
| Inpatient professional services (includes maternity) | $0 | 50% after ded |
| Emergency room (not waived if admitted) | $125 | $125 no ded |
| Routine Radiology — freestanding/hospital-based | $70/$100 | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $175/$215 | 50% after ded/50% after ded |
| Biotech/specialty injectables | $50 | 50% after ded |
| Durable medical equipment/prosthetics | 30% | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $20 | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | $150 per day[11] | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 10% up to $35 max | 50% after ded |
| Hospital-based | 10% up to $155 max | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 | 50% after ded |
| Hospital-based | 50% | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7 | 70% of retail |
| Retail preferred brand[18] | $40 | 70% of retail |
| Retail non-preferred drug[18] | $70 | 70% of retail |
| Specialty drug | 50% up to $1,000 max per fill | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 | Not covered |
| Adult routine eye exam[25] | $0 | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered |
| Pediatric dental deductible (per individual)[29] | $50 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 no ded | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | 50% after ded | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Platinum Preferred[2] $20/$40/$150 | | Keystone DPOS Platinum Preferred[2] $10/$20/$100 | | Keystone DPOS Platinum Preferred[2] $20/$40/$150 | |
|---|---|---|---|---|---|
| **You pay in-network** | **You pay out-of-network[7]** | **You pay in-network** | **You pay out-of-network[5]** | **You pay in-network** | **You pay out-of-network[5]** |
| $0 | $2,000/$4,000 | $0 | $2,000/$4,000 | $0 | $2,000/$4,000 |
| 0% | 50% | 0% | 50% | 0% | 50% |
| $3,000/$6,000 coinsurance and copays | $5,000/$10,000 coinsurance and ded | $3,500/$7,000 coinsurance and copays | $5,000/$10,000 coinsurance and ded | $4,000/$8,000 coinsurance and copays | $5,000/$10,000 coinsurance and ded |
| | | | | | |
| $0 | 50% no ded | $0 | 50% no ded | $0 | 50% no ded |
| $0 | N/A | $0 | N/A | $0 | N/A |
| $750 | 50% no ded | $750 | 50% no ded | $750 | 50% no ded |
| | | | | | |
| $20 | 50% after ded | $10 | 50% after ded | $20 | 50% after ded |
| $40 | 50% after ded | $20 | 50% after ded | $40 | 50% after ded |
| $40 | Not covered | $40 | Not covered | $40 | Not covered |
| $75 | 50% after ded | $75 | 50% after ded | $75 | 50% after ded |
| $40[9] | 50% after ded[9] | $20[10] | 50% after ded | $40[10] | 50% after ded |
| $40/$70[9] | 50% after ded/50% after ded[9] | $20/$20[10] | 50% after ded/50% after ded | $40/$40[10] | 50% after ded/50% after ded |
| | | | | | |
| $150 per day[11] | 50% after ded | $100 per day[11] | 50% after ded | $150 per day[11] | 50% after ded |
| $0 | 50% after ded | $0 | 50% after ded | $0 | 50% after ded |
| $125 | $125 no ded | $125 | $125 no ded | $125 | $125 no ded |
| $70/$100 | 50% after ded/50% after ded | $20/$20[10] | 50% after ded/ 50% after ded | $30/$30[10] | 50% after ded/50% after ded |
| $175/$215 | 50% after ded/50% after ded | $40/$40 | 50% after ded/ 50% after ded | $60/$60 | 50% after ded/50% after ded |
| $75 | 50% after ded | $50 | 50% after ded | $75 | 50% after ded |
| 30% | 50% after ded | 50% | 50% after ded | 50% | 50% after ded |
| $40 | 50% after ded | $20 | 50% after ded | $40 | 50% after ded |
| $150 per day[11] | 50% after ded | $100 per day[11] | 50% after ded | $150 per day[11] | 50% after ded |
| | | | | | |
| 10% up to $45 max | 50% after ded | 10% up to $25 max | 50% after ded | 10% up to $45 max | 50% after ded |
| 10% up to $185 max | 50% after ded | 10% up to $125 max | 50% after ded | 10% up to $185 max | 50% after ded |
| | | | | | |
| $0 | 50% after ded | $0 | 50% after ded | $0 | 50% after ded |
| 50% | 50% after ded | $0 | 50% after ded | $0 | 50% after ded |
| | | | | | |
| $0 | $0 | $0 | $0 | $0 | $0 |
| $7 | 70% of retail | $7 | 70% of retail | $7 | 70% of retail |
| $45 | 70% of retail | $40 | 70% of retail | $45 | 70% of retail |
| $75 | 70% of retail | $70 | 70% of retail | $75 | 70% of retail |
| 50% up to $1,000 max per fill | Not covered | 50% up to $1,000 max per fill | Not covered | 50% up to $1,000 max per fill | Not covered |
| | | | | | |
| $0 | Not covered | $0 | Not covered | $0 | Not covered |
| $0 | Not covered | $0 | Not covered | $0 | Not covered |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered |
| $50 | Not covered | $0 | Not covered | $0 | Not covered |
| $0 no ded | Not covered | $0 | Not covered | $0 | Not covered |
| 50% after ded | Not covered | Copay varies | Not covered | Copay varies | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Platinum health plans | Keystone HMO Platinum Preferred[3] $10/$20/$100 | Keystone HMO Platinum Preferre $20/$40/$150 |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network**[6] | **You pay in-network**[6] |
| Deductible, individual/family | $0 | $0 |
| Coinsurance | 0% | 0% |
| Out-of-pocket maximum, individual/family includes: | $3,500/$7,000 coinsurance and copays | $4,000/$8,000 coinsurance and copays |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 | $0 |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 | $0 |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 | $750 |
| **Physician services** | | |
| Primary care office visit/retail clinic | $10 | $20 |
| Specialist office visit | $20 | $40 |
| Telemedicine† | $40 | $40 |
| Urgent care | $75 | $75 |
| Spinal manipulations (20 visits per year) | $20 | $40 |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $20/$20 | $40/$40 |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | $100 per day[11] | $150 per day[11] |
| Inpatient professional services (includes maternity) | $0 | $0 |
| Emergency room (not waived if admitted) | $125 | $125 |
| Routine Radiology — freestanding/hospital-based | $20/$20 | $30/$30 |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $40/$40 | $60/$60 |
| Biotech/specialty injectables | $50 | $75 |
| Durable medical equipment/prosthetics | 50% | 50% |
| Mental health, serious mental illness, and substance abuse — outpatient | $20 | $40 |
| Mental health, serious mental illness, and substance abuse — inpatient | $100 per day[11] | $150 per day[11] |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 10% up to $25 max | 10% up to $45 max |
| Hospital-based | 10% up to $125 max | 10% up to $185 max |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 | $0 |
| Hospital-based | $0 | $0 |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7 | $7 |
| Retail preferred brand[18] | $40 | $45 |
| Retail non-preferred drug[18] | $70 | $75 |
| Specialty drug | 50% up to $1,000 max per fill | 50% up to $1,000 max per fill |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 | $0 |
| Adult routine eye exam[25] | $0 | $0 |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores |
| Pediatric dental deductible (per individual)[29] | $0 | $0 |
| Pediatric exams and cleanings[29, 30] | $0 | $0 |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Copay varies |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Keystone HMO Platinum Preferred[3] $30/$60/$400 | Personal Choice PPO Platinum HSA — 50[4] $1,600/100% | |
|---|---|---|
| **You pay in-network[6]** | **You pay in-network** | **You pay out-of-network[7]** |
| $0 | $1,600/$3,200 | $10,000/$20,000 |
| 0% | 0% | 50% |
| $4,500/$9,000 coinsurance and copays | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded |
| | | |
| $0 | $0 no ded | 50% no ded |
| $0 | $0 no ded | N/A |
| $750 | $750 no ded | 50% no ded |
| | | |
| $30 | $0 after ded | 50% after ded |
| $60 | $0 after ded | 50% after ded |
| $40 | $0 after ded | Not covered |
| $75 | $0 after ded | 50% after ded |
| $60 | $0 after ded[9] | 50% after ded[9] |
| $60/$60 | $0 after ded/$0 after ded[9] | 50% after ded/50% after ded[9] |
| | | |
| $400 per day[11] | $0 after ded | 50% after ded |
| $0 | $0 after ded | 50% after ded |
| $300 | $0 after ded | $0 after in-network ded |
| $60/$60 | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| $120/$120 | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| $75 | $0 after ded | 50% after ded |
| 50% | $0 after ded | 50% after ded |
| $60 | $0 after ded | 50% after ded |
| $400 per day[11] | $0 after ded | 50% after ded |
| | | |
| 10% up to $45 max | $0 after ded | 50% after ded |
| 10% up to $185 max | $0 after ded | 50% after ded |
| | | |
| $0 | $0 after ded | 50% after ded |
| $0 | $0 after ded | 50% after ded |
| | | |
| $0 | Integrated | Integrated |
| $7 | $7 after ded | 50% after ded |
| $50 | $50 after ded | 50% after ded |
| $100 | $100 after ded | 50% after ded |
| 50% up to $1,000 max per fill | 50% after ded up to $1,000 max per fill | Not covered |
| | | |
| $0 | $0 no ded | Not covered |
| $0 | $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| $0 | Integrated | Not covered |
| $0 | $0 no ded | Not covered |
| Copay varies | $0 after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Gold health plans | Personal Choice PPO Gold Classic[2] $1,000/$15/$30/80% | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[7] |
| Deductible, individual/family | $1,000/$2,000 | $7,500/$15,000 |
| Coinsurance | 20% | 50% |
| Out-of-pocket maximum, individual/family includes: | $5,500/$11,000 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $15 no ded | 50% after ded |
| Specialist office visit | $30 no ded | 50% after ded |
| Telemedicine† | $40 no ded | Not covered |
| Urgent care | 20% after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $30 no ded[9] | 50% after ded[9] |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $30 no ded/$60 no ded[9] | 50% after ded/50% after ded[9] |
| **Hospital/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 (not waived if admitted) | 20% after ded | 20% after in-network ded |
| Routine Radiology — freestanding/hospital-based | 20% after ded/40% after ded | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | 20% after ded/40% after ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $100 no ded | 50% after ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $30 no ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | 20% after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 20% after ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7 | 70% of retail |
| Retail preferred brand[18] | $50 | 70% of retail |
| Retail non-preferred drug[18] | $150 | 70% of retail |
| Specialty drug | 50% up to $1,000 max per fill | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | $50 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 no ded | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | 50% after ded | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Gold Preferred[2] $35/$70/$600 | | Personal Choice PPO Gold Classic[2] $2,000/$40/$80/100% | |
|---|---|---|---|
| **You pay in-network** | **You pay out-of-network[7]** | **You pay in-network** | **You pay out-of-network[7]** |
| $0 | $6,000/$12,000 | $2,000/$4,000 | $7,500/$15,000 |
| 0% | 50% | 0% | 50% |
| $7,350/$14,700 coinsurance and copays | $18,000/$36,000 coinsurance and ded | $4,000/$8,000 coinsurance, copays and ded | $25,000/$50,000 coinsurance and ded |
| | | | |
| $0 | 50% no ded | $0 no ded | 50% no ded |
| $0 | N/A | $0 no ded | N/A |
| $750 | 50% no ded | $750 no ded | 50% no ded |
| | | | |
| $35 | 50% after ded | $40 no ded | 50% after ded |
| $70 | 50% after ded | $80 no ded | 50% after ded |
| $40 | Not covered | $40 no ded | Not covered |
| $125 | 50% after ded | $125 no ded | 50% after ded |
| $70[9] | 50% after ded[9] | $80 no ded[9] | 50% after ded[9] |
| $70/$100[9] | 50% after ded/50% after ded[9] | $80 no ded/$110 no ded[9] | 50% after ded/50% after ded[9] |
| | | | |
| $600 per day[11] | 50% after ded | $0 after ded | 50% after ded |
| $0 | 50% after ded | $0 after ded | 50% after ded |
| $450 | $450 no ded | $300 no ded | $300 no ded |
| $100/$130 | 50% after ded/50% after ded | $70 no ded/$100 no ded | 50% after ded/50% after ded |
| $250/$290 | 50% after ded/50% after ded | $175 no ded/$215 no ded | 50% after ded/50% after ded |
| $125 | 50% after ded | $100 no ded | 50% after ded |
| 50% | 50% after ded | 50% after ded | 50% after ded |
| $70 | 50% after ded | $80 no ded | 50% after ded |
| $600 per day[11] | 50% after ded | $0 after ded | 50% after ded |
| | | | |
| 30% up to $300 max | 50% after ded | $0 after ded | 50% after ded |
| 30% up to $700 max | 50% after ded | 30% after ded | 50% after ded |
| | | | |
| $0 | 50% after ded | $0 no ded | 50% after ded |
| 50% | 50% after ded | 50% after ded | 50% after ded |
| | | | |
| $0 | $0 | $0 | $0 |
| $7 | 70% of retail | $7 | 70% of retail |
| $50 | 70% of retail | $50 | 70% of retail |
| $150 | 70% of retail | $150 | 70% of retail |
| 50% up to $1,000 max per fill | Not covered | 50% up to $1,000 max per fil | Not covered |
| | | | |
| $0 | Not covered | $0 no ded | Not covered |
| $0 | Not covered | $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| $50 | Not covered | $50 | Not covered |
| $0 no ded | Not covered | $0 no ded | Not covered |
| 50% after ded | Not covered | 50% after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Gold health plans | Keystone DPOS Gold Classic[2] $1,000/$25/$50/90% | |
|---|---|---|
| **Benefits per contract year[1]** | **You pay in-network** | **You pay out-of-network[5]** |
| Deductible, individual/family | $1,000/$2,000 | $7,500/$15,000 |
| Coinsurance | 10% | 50% |
| Out-of-pocket maximum, individual/family includes: | $5,500/$11,000 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| **Preventive services[8]** | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $25 no ded | 50% after ded |
| Specialist office visit | $50 no ded | 50% after ded |
| Telemedicine† | $40 no ded | Not covered |
| Urgent care | 10% after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $50 no ded[10] | 50% after ded |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $50 no ded/$50 no ded[10] | 50% after ded/50% after ded |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | 10% after ded | 50% after ded |
| Inpatient professional services (includes maternity) | 10% after ded | 50% after ded |
| Emergency room (not waived if admitted) | 10% after ded | 10% after in-network ded |
| Routine Radiology — freestanding/hospital-based | $40 no ded/$40 no ded[10] | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $80 no ded/$80 no ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $100 no ded | 50% after ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $50 no ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | 10% after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 10% after ded | 50% after ded |
| Hospital-based | 40% after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | 50% after ded |
| Hospital-based | $0 no ded | 50% after ded |
| **Prescription drugs[16, 17, 19, ‡]** | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7 | 70% of retail |
| Retail preferred brand[18] | $50 | 70% of retail |
| Retail non-preferred drug[18] | $150 | 70% of retail |
| Specialty drug | 50% up to $1,000 max per fill | Not covered |
| **Vision and dental[23, 28, 32]** | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | $0 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Keystone DPOS Gold Preferred[2] $30/$60/$650 | |
|---|---|
| **You pay in-network** | **You pay out-of-network[5]** |
| $0 | $5,000/$10,000 |
| 0% | 50% |
| $7,350/$14,700 coinsurance and copays | $15,000/$30,000 coinsurance and ded |
| | |
| $0 | 50% no ded |
| $0 | N/A |
| $750 | 50% no ded |
| | |
| $30 | 50% after ded |
| $60 | 50% after ded |
| $40 | Not covered |
| $125 | 50% after ded |
| $60[10] | 50% after ded |
| $60/$60[10] | 50% after ded/50% after ded |
| | |
| $650 per day[11] | 50% after ded |
| $0 | 50% after ded |
| $450 | $450 no ded |
| $100/$100[10] | 50% after ded/50% after ded |
| $250/$250 | 50% after ded/50% after ded |
| $125 | 50% after ded |
| 50% | 50% after ded |
| $60 | 50% after ded |
| $650 per day[11] | 50% after ded |
| | |
| 30% up to $400 max | 50% after ded |
| 30% up to $750 max | 50% after ded |
| | |
| $0 | 50% after ded |
| $0 | 50% after ded |
| | |
| $0 | $0 |
| $7 | 70% of retail |
| $50 | 70% of retail |
| $150 | 70% of retail |
| 50% up to $1,000 max per fill | Not covered |
| | |
| $0 | Not covered |
| $0 | Not covered |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Not covered |
| $0 | Not covered |
| $0 | Not covered |
| Copay varies | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Gold health plans | Keystone HMO Gold Classic[2] $1,000/$25/$50/90% | Keystone HMO Gold Classic[2] $2,000/$40/$80/100% | Keystone HMO Gold Preferred[3] $30/$60/$650 |
|---|---|---|---|
| **Benefits per contract year[1]** | **You pay in-network[6]** | **You pay in-network[6]** | **You pay in-network[6]** |
| Deductible, individual/family | $1,000/$2,000 | $2,000/$4,000 | $0 |
| Coinsurance | 10% | 0% | 0% |
| Out-of-pocket maximum, individual/family includes: | $5,500/$11,000 coinsurance, copays, and ded | $4,000/$8,000 coinsurance, copays, and ded | $7,350/$14,700 coinsurance and copays |
| **Preventive services[8]** | | | |
| Preventive care for adults and children | $0 no ded | $0 no ded | $0 |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | $0 no ded | $0 |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | $750 no ded | $750 |
| **Physician services** | | | |
| Primary care office visit/retail clinic | $25 no ded | $40 no ded | $30 |
| Specialist office visit | $50 no ded | $80 no ded | $60 |
| Telemedicine† | $40 no ded | $40 no ded | $40 |
| Urgent care | 10% after ded | $125 no ded | $125 |
| Spinal manipulations (20 visits per year) | $50 no ded | $80 no ded | $60 |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $50 no ded/$50 no ded | $80 no ded/$80 no ded | $60/$60 |
| **Hospital/other medical services** | | | |
| Inpatient hospital services (includes maternity) | 10% after ded | $0 after ded | $650 per day[11] |
| Inpatient professional services (includes maternity) | 10% after ded | $0 after ded | $0 |
| Emergency room (not waived if admitted) | 10% after ded | $300 no ded | $450 |
| Routine Radiology — freestanding/hospital-based | $40 no ded/$40 no ded | $60 no ded/$60 no ded | $100/$100 |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $80 no ded/$80 no ded | $120 no ded/$120 no ded | $250/$250 |
| Biotech/specialty injectables | $100 no ded | $100 no ded | $125 |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded | 50% |
| Mental health, serious mental illness, and substance abuse — outpatient | $50 no ded | $80 no ded | $60 |
| Mental health, serious mental illness, and substance abuse — inpatient | 10% after ded | $0 after ded | $650 per day[11] |
| **Outpatient surgery** | | | |
| Ambulatory surgical facility | 10% after ded | $0 after ded | 30% up to $400 max |
| Hospital-based | 40% after ded | 30% after ded | 30% up to $750 max |
| **Outpatient lab/pathology** | | | |
| Freestanding | $0 no ded | $0 no ded | $0 |
| Hospital-based | $0 no ded | $0 no ded | $0 |
| **Prescription drugs[16, 17, 19, ‡]** | | | |
| Rx deductible (individual/family) | $0 | $0 | $0 |
| Retail generic[18] | $7 | $7 | $7 |
| Retail preferred brand[18] | $50 | $50 | $50 |
| Retail non-preferred drug[18] | $150 | $150 | $150 |
| Specialty drug | 50% up to $1,000 max per fill | 50% up to $1,000 max per fill | 50% up to $1,000 max per fill |
| **Vision and dental[23, 28, 32]** | | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | $0 no ded | $0 |
| Adult routine eye exam[25] | $0 no ded | $0 no ded | $0 |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores |
| Pediatric dental deductible (per individual)[29] | $0 | $0 | $0 |
| Pediatric exams and cleanings[29, 30] | $0 | $0 | $0 |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Copay varies | Copay varies |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

## Keystone HMO Gold Proactive[3]

| You pay in-network[6] - Tier 1 - Preferred | You pay in-network[6] - Tier 2 - Enhanced | You pay in-network[6] - Tier 3 - Standard |
|---|---|---|
| $0 | $0 | $0 |
| 0%; unless otherwise noted | 20%; unless otherwise noted | 30%; unless otherwise noted |
| $7,350/$14,700[12] coinsurance and copays | $7,350/$14,700[12] coinsurance and copays | $7,350/$14,700[12] coinsurance and copays |
| | | |
| $0 | $0 | $0 |
| $0 | $0 | $0 |
| $750 | $750 | $750 |
| | | |
| $15[13] | $30[13] | $45[13] |
| $40 | $60 | $80 |
| $40 | $40 | $40 |
| $100 | $100 | $100 |
| $50 | $50 | $50 |
| $60/$60 | $60/$60 | $60/$60 |
| | | |
| $350 per day[11, 14] | $700 per day[11, 14] | $1,100 per day[11, 14] |
| 0% | 20% | 30%[14] |
| $400 | $400 | $400 |
| $60/$60 | $60/$60 | $60/$60 |
| $120/$120 | $120/$120 | $120/$120 |
| 50% | 50% | 50% |
| 50% | 50% | 50% |
| $40 | $40 | $40 |
| $350 per day[11] | $350 per day[11] | $350 per day[11] |
| | | |
| $150 | $550 | $1,000 |
| $150 | $550 | $1,000 |
| | | |
| $0 | $0 | $0 |
| $0 | $0 | $0 |
| | | |
| $0 | $0 | $0 |
| $15[20, 22] | $15[20, 22] | $15[20, 22] |
| 50% up to $200 max per fill[20, 21] | 50% up to $200 max per fill[20, 21] | 50% up to $200 max per fill[20, 21] |
| 50% up to $300 max per fill[20, 21] | 50% up to $300 max per fill[20, 21] | 50% up to $300 max per fill[20, 21] |
| 50% up to $1,000 max per fill[20, 21] | 50% up to $1,000 max per fill[20, 21] | 50% up to $1,000 max per fill[20, 21] |
| | | |
| $0 | $0 | $0 |
| $0 | $0 | $0 |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores |
| $0 | $0 | $0 |
| $0 | $0 | $0 |
| Copay varies | Copay varies | Copay varies |

Footnotes begin on page 45 | ded = Deductible

| Gold health plans | Personal Choice PPO Gold HSA - 0[4] $1,900/100% | | Personal Choice PPO Gold HSA - 25[4] $2,400/90% | |
|---|---|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[7] | **You pay in-network** | **You pay out-of-network**[7] |
| Deductible, individual/family | $1,900/$3,800 | $10,000/$20,000 | $2,400/$4,800 | $10,000/$20,000 |
| Coinsurance | 0% | 50% | 10% | 50% |
| Out-of-pocket maximum, individual/family includes: | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded |
| **Preventive services**[8] | | | | |
| Preventive care for adults and children | $0 no ded | 50% no ded | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded | $750 no ded | 50% no ded |
| **Physician services** | | | | |
| Primary care office visit/retail clinic | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Specialist office visit | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Telemedicine† | $0 after ded | Not covered | 10% after ded | Not covered |
| Urgent care | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $0 after ded[9] | 50% after ded[9] | 10% after ded[9] | 50% after ded[9] |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $0 after ded/$0 after ded[9] | 50% after ded/50% after ded[9] | 10% after ded/10% after ded[9] | 50% after ded/50% after ded[9] |
| **Hospital/other medical services** | | | | |
| Inpatient hospital services (includes maternity) | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Inpatient professional services (includes maternity) | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Emergency room (not waived if admitted) | $0 after ded | $0 after in-network ded | 10% after ded | 10% after in-network ded |
| Routine Radiology — freestanding/hospital-based | $0 after ded/$0 after ded | 50% after ded/50% after ded | 10% after ded/10% after ded | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $0 after ded/$0 after ded | 50% after ded/50% after ded | 10% after ded/10% after ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Durable medical equipment/prosthetics | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| **Outpatient surgery** | | | | |
| Ambulatory surgical facility | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Hospital-based | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| **Outpatient lab/pathology** | | | | |
| Freestanding | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| Hospital-based | $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | | | |
| Rx deductible (individual/family) | Integrated | Integrated | Integrated | Integrated |
| Retail generic[18] | $7 after ded | 50% after ded | $7 after ded | 50% after ded |
| Retail preferred brand[18] | $50 after ded | 50% after ded | $50 after ded | 50% after ded |
| Retail non-preferred drug[18] | $100 after ded | 50% after ded | $100 after ded | 50% after ded |
| Specialty drug | 50% after ded up to $1,000 max per fill | Not covered | 50% after ded up to $1,000 max per fill | Not covered |
| **Vision and dental**[23, 28, 32] | | | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | Integrated | Not covered | Integrated | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 no ded | Not covered | $0 no ded | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | $0 after ded | Not covered | 10% after ded | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Gold HSA - 50[4] $2,650/60% | | Personal Choice PPO Gold HRA - 25[2] $2,900/100% | |
|---|---|---|---|
| **You pay in-network** | **You pay out-of-network[7]** | **You pay in-network** | **You pay out-of-network[7]** |
| $2,650/$5,300 | $10,000/$20,000 | $2,900/$5,800 | $10,000/$20,000 |
| 40% | 50% | 0% | 50% |
| $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded |
| | | | |
| $0 no ded | 50% no ded | $0 no ded | 50% no ded |
| $0 no ded | N/A | $0 no ded | N/A |
| $750 no ded | 50% no ded | $750 no ded | 50% no ded |
| | | | |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | Not covered | $0 after ded | Not covered |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded[9] | 50% after ded[9] | $0 after ded[9] | 50% after ded[9] |
| 40% after ded/40% after ded[9] | 50% after ded/50% after ded[9] | $0 after ded/$0 after ded[9] | 50% after ded/50% after ded[9] |
| | | | |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 40% after in-network ded | $0 after ded | $0 after in-network ded |
| 40% after ded/40% after ded | 50% after ded/50% after ded | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| 40% after ded/40% after ded | 50% after ded/50% after ded | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| | | | |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| | | | |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| 40% after ded | 50% after ded | $0 after ded | 50% after ded |
| | | | |
| Integrated | Integrated | Integrated | Integrated |
| $7 after ded | 50% after ded | $7 after ded | 50% after ded |
| $50 after ded | 50% after ded | $50 after ded | 50% after ded |
| $100 after ded | 50% after ded | $100 after ded | 50% after ded |
| 50% after ded up to $1,000 max per fill | Not covered | 50% after ded up to $1,000 max per fill | Not covered |
| | | | |
| $0 no ded | Not covered | $0 no ded | Not covered |
| $0 no ded | Not covered | $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Integrated | Not covered | Integrated | Not covered |
| $0 no ded | Not covered | $0 no ded | Not covered |
| 40% after ded | Not covered | $0 after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Silver health plans | Personal Choice PPO Silver Classic[2] $3,000/$30/$60/70% | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[7] |
| Deductible, individual/family | $3,000/$6,000 | $7,500/$15,000 |
| Coinsurance | 30% | 50% |
| Out-of-pocket maximum, individual/family includes: | $7,350/$14,700 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $30 no ded | 50% after ded |
| Specialist office visit | $60 no ded | 50% after ded |
| Telemedicine† | $40 no ded | Not covered |
| Urgent care | $125 no ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $60 no ded[9] | 50% after ded[9] |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $60 no ded/$90 no ded[9] | 50% after ded/50% after ded[9] |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | 30% after ded | 50% after ded |
| Inpatient professional services (includes maternity) | 30% after ded | 50% after ded |
| Emergency room (not waived if admitted) | 30% after ded | 30% after in-network ded |
| Routine Radiology — freestanding/hospital-based | 30% after ded/50% after ded | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | 30% after ded/50% after ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $100 no ded | 50% after ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $60 no ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | 30% after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 30% after ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7[20] | 70% of retail |
| Retail preferred brand[18] | 50% up to $125 max per fill[20, 21] | 70% of retail[21] |
| Retail non-preferred drug[18] | 50% up to $250 max per fill[20, 21] | 70% of retail[21] |
| Specialty drug | 50% up to $1,000 max per fill[20, 21] | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | $50 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 no ded | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | 50% after ded | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Silver Secure[2] $4,250/$30/$60/$600 | | Personal Choice PPO Silver Classic[2] $4,750/$50/$100/90% | |
|---|---|---|---|
| **You pay in-network** | **You pay out-of-network[7]** | **You pay in-network** | **You pay out-of-network[7]** |
| $4,250/$8,500 | $7,500/$15,000 | $4,750/$9,500 | $7,500/$15,000 |
| 0% | 50% | 10% | 50% |
| $7,350/$14,700 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded | $7,350/$14,700 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| | | | |
| $0 no ded | 50% no ded | $0 no ded | 50% no ded |
| $0 no ded | N/A | $0 no ded | N/A |
| $750 no ded | 50% no ded | $750 no ded | 50% no ded |
| | | | |
| $30 no ded | 50% after ded | $50 no ded | 50% after ded |
| $60 no ded | 50% after ded | $100 no ded | 50% after ded |
| $40 no ded | Not covered | $40 no ded | Not covered |
| $125 no ded | 50% after ded | $125 no ded | 50% after ded |
| $60 no ded[9] | 50% after ded[9] | $100 no ded[9] | 50% after ded[9] |
| $60 no ded/$90 no ded[9] | 50% after ded/50% after ded[9] | $100 no ded/$130 no ded[9] | 50% after ded/50% after ded[9] |
| | | | |
| Subject to ded and $600/day[11] | 50% after ded | 10% after ded | 50% after ded |
| $0 after ded | 50% after ded | 10% after ded | 50% after ded |
| $450 after ded | $450 after in-network ded | $300 after ded | $300 after in-network ded |
| $70 after ded/$100 after ded | 50% after ded/50% after ded | $100 no ded/$130 no ded | 50% after ded/50% after ded |
| $175 after ded/$215 after ded | 50% after ded/50% after ded | $250 no ded/$290 no ded | 50% after ded/50% after ded |
| $100 no ded | 50% after ded | $100 no ded | 50% after ded |
| 50% after ded | 50% after ded | 50% after ded | 50% after ded |
| $60 no ded | 50% after ded | $100 no ded | 50% after ded |
| Subject to ded and $600/day[11] | 50% after ded | 10% after ded | 50% after ded |
| | | | |
| 40% up to $600 max after ded | 50% after ded | 10% after ded | 50% after ded |
| 40% up to $600 max after ded | 50% after ded | 30% after ded | 50% after ded |
| | | | |
| $0 no ded | 50% after ded | $0 no ded | 50% after ded |
| 50% after ded | 50% after ded | 50% after ded | 50% after ded |
| | | | |
| $0 | $0 | $0 | $0 |
| $7[20] | 70% of retail | $7[20] | 70% of retail |
| $60[20, 21] | 70% of retail[21] | $60[20, 21] | 70% of retail[21] |
| $150[20, 21] | 70% of retail[21] | $150[20, 21] | 70% of retail[21] |
| 50% up to $1,000 max per fill[20, 21] | Not covered | 50% up to $1,000 max per fill[20, 21] | Not covered |
| | | | |
| $0 no ded | Not covered | $0 no ded | Not covered |
| $0 no ded | Not covered | $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| $50 | Not covered | $50 | Not covered |
| $0 no ded | Not covered | $0 no ded | Not covered |
| 50% after ded | Not covered | 50% after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Silver health plans | Keystone DPOS Silver Classic[2] $4,000/$25/$50/70% | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[5] |
| Deductible, individual/family | $4,000/$8,000 | $7,500/$15,000 |
| Coinsurance | 30% | 50% |
| Out-of-pocket maximum, individual/family includes: | $7,350/$14,700 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $25 no ded | 50% after ded |
| Specialist office visit | $50 no ded | 50% after ded |
| Telemedicine† | $40 no ded | Not covered |
| Urgent care | 30% after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $50 no ded[10] | 50% after ded |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $50 no ded/$50 no ded[10] | 50% after ded/50% after ded |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | 30% after ded | 50% after ded |
| Inpatient professional services (includes maternity) | 30% after ded | 50% after ded |
| Emergency room (not waived if admitted) | 30% after ded | 30% after in-network ded |
| Routine Radiology — freestanding/hospital-based | $100 no ded/$100 no ded[10] | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $250 no ded/$250 no ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $100 no ded | 50% after ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $50 no ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | 30% after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 30% after ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | 50% after ded |
| Hospital-based | $0 no ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18] | $7[20] | 70% of retail |
| Retail preferred brand[18] | 50% up to $125 max per fill[20, 21] | 70% of retail[21] |
| Retail non-preferred drug[18] | 50% up to $250 max per fill[20, 21] | 70% of retail[21] |
| Specialty drug | 50% up to $1,000 max per fill[20, 21] | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | $0 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Keystone DPOS Silver Classic[2] $3,250/$30/$60/50% | |
|---|---|
| **You pay in-network** | **You pay out-of-network[5]** |
| $3,250/$6,500 | $7,500/$15,000 |
| 50% | 50% |
| $7,350/$14,700 coinsurance, copays, and ded | $25,000/$50,000 coinsurance and ded |
| | |
| $0 no ded | 50% no ded |
| $0 no ded | N/A |
| $750 no ded | 50% no ded |
| | |
| $30 no ded | 50% after ded |
| $60 no ded | 50% after ded |
| $40 no ded | Not covered |
| 50% after ded | 50% after ded |
| $60 no ded[10] | 50% after ded |
| $60 no ded/$60 no ded[10] | 50% after ded/50% after ded |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after in-network ded |
| $60 no ded/$60 no ded[10] | 50% after ded/50% after ded |
| $250 no ded/$250 no ded | 50% after ded/50% after ded |
| $100 no ded | 50% after ded |
| 50% after ded | 50% after ded |
| $60 no ded | 50% after ded |
| 50% after ded | 50% after ded |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| | |
| $0 no ded | 50% after ded |
| $0 no ded | 50% after ded |
| | |
| $0 | $0 |
| $7[20] | 70% of retail |
| 50% up to $125 max per fill[20, 21] | 70% of retail[21] |
| 50% up to $250 max per fill[20, 21] | 70% of retail[21] |
| 50% up to $1,000 max per fill[20, 21] | Not covered |
| | |
| $0 no ded | Not covered |
| $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| $0 | Not covered |
| $0 | Not covered |
| Copay varies | Not covered |

Footnotes begin on page 45 | ded = Deductible

| Silver health plans | Keystone HMO Silver Classic[2] $4,000/$25/$50/70% | Keystone HMO Silver Classic[2] $3,250/$30/$60/50% |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network**[6] | **You pay in-network**[6] |
| Deductible, individual/family | $4,000/$8,000 | $3,250/$6,500 |
| Coinsurance | 30% | 50% |
| Out-of-pocket maximum, individual/family includes: | $7,350/$14,700 coinsurance, copays, and ded | $7,350/$14,700 coinsurance, copays, and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | $0 no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | $0 no ded |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | $750 no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $25 no ded | $30 no ded |
| Specialist office visit | $50 no ded | $60 no ded |
| Telemedicine† | $40 no ded | $40 no ded |
| Urgent care | 30% after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $50 no ded | $60 no ded |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $50 no ded/$50 no ded | $60 no ded/$60 no ded |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | 30% after ded | 50% after ded |
| Inpatient professional services (includes maternity) | 30% after ded | 50% after ded |
| Emergency room (not waived if admitted) | 30% after ded | 50% after ded |
| Routine Radiology — freestanding/hospital-based | $100 no ded/$100 no ded | $60 no ded/$60 no ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $250 no ded/$250 no ded | $250 no ded/$250 no ded |
| Biotech/specialty injectables | $100 no ded | $100 no ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $50 no ded | $60 no ded |
| Mental health, serious mental illness, and substance abuse — inpatient | 30% after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 30% after ded | 50% after ded |
| Hospital-based | 50% after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | $0 no ded |
| Hospital-based | $0 no ded | $0 no ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | $0 | $0 |
| Retail generic[18,20] | $7 | $7 |
| Retail preferred brand[18, 20, 21] | 50% up to $125 max per fill | 50% up to $125 max per fill |
| Retail non-preferred drug[18, 20, 21] | 50% up to $250 max per fill | 50% up to $250 max per fill |
| Specialty drug[20, 21] | 50% up to $1,000 max per fill | 50% up to $1,000 max per fill |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24, 25] and eyewear (glasses or contacts)[24, 26] | $0 no ded | $0 no ded |
| Adult routine eye exam[25] | $0 no ded | $0 no ded |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded |
| Pediatric dental deductible (per individual)[29] | $0 | $0 |
| Pediatric exams and cleanings[29, 30] | $0 | $0 |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Copay varies |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Keystone HMO Silver Classic[2] $4,250/$40/$80/100% | Keystone HMO Silver Secure[2] $4,500/$40/$80/$600 |
|---|---|
| **You pay in-network[6]** | **You pay in-network[6]** |
| $4,250/$8,500 | $4,500/$9,000 |
| 0% | 0% |
| $7,350/$14,700 coinsurance, copays, and ded | $7,350/$14,700 coinsurance, copays, and ded |
| | |
| $0 no ded | $0 no ded |
| $0 no ded | $0 no ded |
| $750 no ded | $750 no ded |
| | |
| $40 no ded | $40 no ded |
| $80 no ded | $80 no ded |
| $40 no ded | $40 no ded |
| $125 no ded | $125 after ded |
| $80 no ded | $80 no ded |
| $80 no ded/$80 no ded | $80 no ded/$80 no ded |
| | |
| $0 after ded | Subject to ded and $600/day[11] |
| $0 after ded | $0 after ded |
| $300 after ded | $300 after ded |
| $100 no ded/$100 no ded | $100 no ded/$100 no ded |
| $250 no ded/$250 no ded | $250 no ded/$250 no ded |
| $100 no ded | $100 no ded |
| 50% after ded | 50% after ded |
| $80 no ded | $80 no ded |
| $0 after ded | Subject to ded and $600/day[11] |
| | |
| $0 after ded | 30% up to $600 max after ded |
| 30% after ded | 30% up to $600 max after ded |
| | |
| $0 no ded | $0 no ded |
| $0 no ded | $0 no ded |
| | |
| $0 | $0 |
| $7 | $7 |
| 50% up to $125 max per fill | $60 |
| 50% up to $250 max per fill | $150 |
| 50% up to $1,000 max per fill | 50% up to $1,000 max per fill |
| | |
| $0 no ded | $0 no ded |
| $0 no ded | $0 no ded |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded |
| $0 | $0 |
| $0 | $0 |
| Copay varies | Copay varies |

Footnotes begin on page 45 | ded = Deductible

# Silver health plans

| Benefits per contract year[1] |
|---|
| Deductible, individual/family |
| Coinsurance |
| Out-of-pocket maximum, individual/family includes: |
| **Preventive services[8]** |
| Preventive care for adults and children |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based |
| **Physician services** |
| Primary care office visit/retail clinic |
| Specialist office visit |
| Telemedicine† |
| Urgent care |
| Spinal manipulations (20 visits per year) |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based |
| **Hospital/other medical services** |
| Inpatient hospital services (includes maternity) |
| Inpatient professional services (includes maternity) |
| Emergency room (not waived if admitted) |
| Routine Radiology — freestanding/hospital-based |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based |
| Biotech/specialty injectables |
| Durable medical equipment/prosthetics |
| Mental health, serious mental illness, and substance abuse — outpatient |
| Mental health, serious mental illness, and substance abuse — inpatient |
| **Outpatient surgery** |
| Ambulatory surgical facility |
| Hospital-based |
| **Outpatient lab/pathology** |
| Freestanding |
| Hospital-based |
| **Prescription drugs[16, 17, 19, ‡]** |
| Rx deductible (individual/family) |
| Retail generic[18, 20, 22] |
| Retail preferred brand[18, 20, 21] |
| Retail non-preferred drug[18, 20, 21] |
| Specialty drug[20, 21] |
| **Vision and dental[23, 28, 32]** |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] |
| Adult routine eye exam[25] |
| Adult eyewear (glasses or contacts)[27] |
| Pediatric dental deductible (per individual)[29] |
| Pediatric exams and cleanings[29, 30] |
| Pediatric basic, major, and orthodontia services[29, 31] |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

## Keystone HMO Silver Proactive[2]

| You pay in-network[6] – Tier 1 – Preferred | You pay in-network[6] – Tier 2 – Enhanced | You pay in-network[6] – Tier 3 – Standard |
|---|---|---|
| $0 | $5,500/$11,000[15] | $5,500/$11,000[15] |
| 0%; unless otherwise noted | 5%; unless otherwise noted | 10%; unless otherwise noted |
| $7,350/$14,700[12] coinsurance and copays | $7,350/$14,700[12] coinsurance, copays, and ded | $7,350/$14,700[12] coinsurance, copays, and ded |
| | | |
| $0 | $0 no ded | $0 no ded |
| $0 | $0 no ded | $0 no ded |
| $750 | $750 no ded | $750 no ded |
| | | |
| $40[13] | $50 no ded[13] | $60 no ded[13] |
| $80 | $100 no ded | $120 no ded |
| $40 | $40 no ded | $40 no ded |
| $100 | $100 no ded | $100 no ded |
| $50 | $50 no ded | $50 no ded |
| $80/$80 | $80 no ded/$80 no ded | $80 no ded/$80 no ded |
| | | |
| $500 per day[11, 14] | Subject to ded and $900 per day[11, 14] | Subject to ded and $1,300 per day[11, 14] |
| 0% | 5% after ded | 10% after ded[14] |
| $550 | $550 no ded | $550 no ded |
| $120/$120 | $120 no ded/$120 no ded | $120 no ded/$120 no ded |
| $250/$250 | $250 no ded/$250 no ded | $250 no ded/$250 no ded |
| 50% | 50% no ded | 50% no ded |
| 50% | 50% no ded | 50% no ded |
| $80 | $80 no ded | $80 no ded |
| $500 per day[11] | $500 per day[11] no ded | $500 per day[11] no ded |
| | | |
| $250 | Subject to ded and $750 copay | Subject to ded and $1,250 copay |
| $250 | Subject to ded and $750 copay | Subject to ded and $1,250 copay |
| | | |
| $0 | $0 no ded | $0 no ded |
| $0 | $0 no ded | $0 no ded |
| | | |
| $0 | $0 | $0 |
| $15 | $15 | $15 |
| 50% up to $400 max per fill | 50% up to $400 max per fill | 50% up to $400 max per fill |
| 50% up to $500 max per fill | 50% up to $500 max per fill | 50% up to $500 max per fill |
| 50% up to $1,000 max per fill | 50% up to $1,000 max per fill | 50% up to $1,000 max per fill |
| | | |
| $0 | $0 no ded | $0 no ded |
| $0 | $0 no ded | $0 no ded |
| Allowance up to $100 for frames or contact lenses; $150 frame allowance at Visionworks stores | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded |
| $0 | $0 | $0 |
| $0 | $0 | $0 |
| Copay varies | Copay varies | Copay varies |

Footnotes begin on page 45 | ded = Deductible

| Silver health plans | Personal Choice PPO Silver HSA - O[4] $3,200/100% | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[7] |
| Deductible, individual/family | $3,200/$6,400 | $10,000/$20,000 |
| Coinsurance | 0% | 50% |
| Out-of-pocket maximum, individual/family includes: | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $0 after ded | 50% after ded |
| Specialist office visit | $0 after ded | 50% after ded |
| Telemedicine† | $0 after ded | Not covered |
| Urgent care | $0 after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $0 after ded[9] | 50% after ded[9] |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $0 after ded/$0 after ded[9] | 50% after ded/50% after ded[9] |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | $0 after ded | 50% after ded |
| Inpatient professional services (includes maternity) | $0 after ded | 50% after ded |
| Emergency room (not waived if admitted) | $0 after ded | $0 after in-network ded |
| Routine Radiology — freestanding/hospital-based | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $0 after ded | 50% after ded |
| Durable medical equipment/prosthetics | $0 after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $0 after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | $0 after ded | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | $0 after ded | 50% after ded |
| Hospital-based | $0 after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 after ded | 50% after ded |
| Hospital-based | $0 after ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | Integrated | Integrated |
| Retail generic[18] | $7 after ded[20] | 50% after ded |
| Retail preferred brand[18] | $50 after ded[20, 21] | 50% after ded[21] |
| Retail non-preferred drug[18] | $100 after ded[20, 21] | 50% after ded[21] |
| Specialty drug | 50% after ded up to $1,000 max per fill[20, 21] | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | Integrated | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 no ded | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | 0% after ded | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Silver HSA - O[4]<br>$2,700/90% | |
|---|---|
| **You pay in-network** | **You pay out-of-network[7]** |
| $2,700/$5,400 | $10,000/$20,000 |
| 10% | 50% |
| $6,650/$13,300<br>coinsurance, copays, and ded | $20,000/$40,000<br>coinsurance and ded |
| | |
| $0 no ded | 50% no ded |
| $0 no ded | N/A |
| $750 no ded | 50% no ded |
| | |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| 10% after ded | Not covered |
| 10% after ded | 50% after ded |
| 10% after ded[9] | 50% after ded[9] |
| 10% after ded/10% after ded[9] | 50% after ded/50% after ded[9] |
| | |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| 10% after ded | 10% after in-network ded |
| 10% after ded/10% after ded | 50% after ded/50% after ded |
| 10% after ded/10% after ded | 50% after ded/50% after ded |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| | |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| | |
| 10% after ded | 50% after ded |
| 10% after ded | 50% after ded |
| | |
| Integrated | Integrated |
| $7 after ded[20] | 50% after ded |
| $50 after ded[20, 21] | 50% after ded[21] |
| $100 after ded[20, 21] | 50% after ded[21] |
| 50% after ded up to $1,000 max per fill[20, 21] | Not covered |
| | |
| $0 no ded | Not covered |
| $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded;<br>$150 frame allowance at Visionworks stores, no ded | Not covered |
| Integrated | Not covered |
| $0 no ded | Not covered |
| 10% after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

# Silver health plans

| Benefits per contract year[1] |
|---|
| Deductible, individual/family |
| Coinsurance |
| Out-of-pocket maximum, individual/family includes: |
| **Preventive services[8]** |
| Preventive care for adults and children |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based |
| **Physician services** |
| Primary care office visit/retail clinic |
| Specialist office visit |
| Telemedicine† |
| Urgent care |
| Spinal manipulations (20 visits per year) |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based |
| **Hospital/other medical services** |
| Inpatient hospital services (includes maternity) |
| Inpatient professional services (includes maternity) |
| Emergency room (not waived if admitted) |
| Routine Radiology — freestanding/hospital-based |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based |
| Biotech/specialty injectables |
| Durable medical equipment/prosthetics |
| Mental health, serious mental illness, and substance abuse — outpatient |
| Mental health, serious mental illness, and substance abuse — inpatient |
| **Outpatient surgery** |
| Ambulatory surgical facility |
| Hospital-based |
| **Outpatient lab/pathology** |
| Freestanding |
| Hospital-based |
| **Prescription drugs[16, 17, 19, ‡]** |
| Rx deductible (individual/family) |
| Retail generic[18] |
| Retail preferred brand[18] |
| Retail non-preferred drug[18] |
| Specialty drug |
| **Vision and dental[23, 28, 32]** |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] |
| Adult routine eye exam[25] |
| Adult eyewear (glasses or contacts)[27] |
| Pediatric dental deductible (per individual)[29] |
| Pediatric exams and cleanings[29, 30] |
| Pediatric basic, major, and orthodontia services[29, 31] |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Silver HSA - O[4] $2,100/70% | | Personal Choice EPO Silver HSA-O[4] $3,000/80% |
|---|---|---|
| **You pay in-network** | **You pay out-of-network[7]** | **You pay in-network[6]** |
| $2,100/$4,200 | $10,000/$20,000 | $3,000/$6,000 |
| 30% | 50% | 20% |
| $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded | $6,650/$13,300 coinsurance, copays, and ded |
| | | |
| $0 no ded | 50% no ded | $0 no ded |
| $0 no ded | N/A | $0 no ded |
| $750 no ded | 50% no ded | $750 no ded |
| | | |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | Not covered | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded[9] | 50% after ded[9] | 20% after ded |
| 30% after ded/30% after ded[9] | 50% after ded/50% after ded[9] | 20% after ded/20% after ded |
| | | |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 30% after in-network ded | 20% after ded |
| 30% after ded/30% after ded | 50% after ded/50% after ded | 20% after ded/20% after ded |
| 30% after ded/30% after ded | 50% after ded/50% after ded | 20% after ded/20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| | | |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| | | |
| 30% after ded | 50% after ded | 20% after ded |
| 30% after ded | 50% after ded | 20% after ded |
| | | |
| Integrated | Integrated | Integrated |
| $7 after ded[20] | 50% after ded | $7 after ded[20] |
| $50 after ded[20, 21] | 50% after ded[21] | $50 after ded[20, 21] |
| $100 after ded[20, 21] | 50% after ded[21] | $100 after ded[20, 21] |
| 50% after ded up to $1,000 max per fill[20, 21] | Not covered | 50% after ded up to $1,000 max per fill[20, 21] |
| | | |
| $0 no ded | Not covered | $0 no ded |
| $0 no ded | Not covered | $0 no ded |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded |
| Integrated | Not covered | Integrated |
| $0 no ded | Not covered | $0 no ded |
| 30% after ded | Not covered | 20% after ded |

Footnotes begin on page 45 | ded = Deductible

| Bronze health plans | Keystone DPOS Bronze Essential[2] $6,850/$50/$100/$700 | |
|---|---|---|
| **Benefits per contract year**[1] | **You pay in-network** | **You pay out-of-network**[5] |
| Deductible, individual/family | $6,850/$13,700 | $10,000/$20,000 |
| Coinsurance | 50% | 50% |
| Out-of-pocket maximum, individual/family includes: | $7,350/$14,700 coinsurance, copays, and ded | $40,000/$80,000 coinsurance and ded |
| **Preventive services**[8] | | |
| Preventive care for adults and children | $0 no ded | 50% no ded |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers | $0 no ded | N/A |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based | $750 no ded | 50% no ded |
| **Physician services** | | |
| Primary care office visit/retail clinic | $50 no ded | 50% after ded |
| Specialist office visit | $100 no ded | 50% after ded |
| Telemedicine† | $40 no ded | Not covered |
| Urgent care | $150 after ded | 50% after ded |
| Spinal manipulations (20 visits per year) | $100 no ded[10] | 50% after ded |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based | $80 no ded/$80 no ded[10] | 50% after ded/50% after ded |
| **Hospital/other medical services** | | |
| Inpatient hospital services (includes maternity) | Subject to ded and $700/day[11] | 50% after ded |
| Inpatient professional services (includes maternity) | 50% after ded | 50% after ded |
| Emergency room (not waived if admitted) | $500 after ded | $500 after in-network ded |
| Routine Radiology — freestanding/hospital-based | $100 no ded/$100 no ded[10] | 50% after ded/50% after ded |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based | $250 no ded/$250 no ded | 50% after ded/50% after ded |
| Biotech/specialty injectables | $100 no ded | 50% after ded |
| Durable medical equipment/prosthetics | 50% after ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — outpatient | $100 no ded | 50% after ded |
| Mental health, serious mental illness, and substance abuse — inpatient | Subject to ded and $700/day[11] | 50% after ded |
| **Outpatient surgery** | | |
| Ambulatory surgical facility | 30% up to $750 max after ded | 50% after ded |
| Hospital-based | 30% up to $750 max after ded | 50% after ded |
| **Outpatient lab/pathology** | | |
| Freestanding | $0 no ded | 50% after ded |
| Hospital-based | $0 no ded | 50% after ded |
| **Prescription drugs**[16, 17, 19, ‡] | | |
| Rx deductible (individual/family) | Integrated | Integrated |
| Retail generic[18] | $15 after ded[20] | 70% of retail after ded |
| Retail preferred brand[18] | 50% after ded up to $500 max per fill[20, 21] | 70% of retail after ded[21] |
| Retail non-preferred drug[18] | 50% after ded up to $500 max per fill[20, 21] | 70% of retail after ded[21] |
| Specialty drug | 50% after ded up to $1,000 max per fill[20, 21] | Not covered |
| **Vision and dental**[23, 28, 32] | | |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] | $0 no ded | Not covered |
| Adult routine eye exam[25] | $0 no ded | Not covered |
| Adult eyewear (glasses or contacts)[27] | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| Pediatric dental deductible (per individual)[29] | $0 | Not covered |
| Pediatric exams and cleanings[29, 30] | $0 | Not covered |
| Pediatric basic, major, and orthodontia services[29, 31] | Copay varies | Not covered |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Keystone HMO Bronze Essential[2] $6,850/$50/$100/$700 | Personal Choice PPO Bronze HSA - O[4] $6,650/100% | |
|---|---|---|
| **You pay in-network[6]** | **You pay in-network** | **You pay out-of-network[7]** |
| $6,850/$13,700 | $6,650/$13,300 | $10,000/$20,000 |
| 50% | 0% | 50% |
| $7,350/$14,700 coinsurance, copays, and ded | $6,650/$13,300 coinsurance, copays, and ded | $20,000/$40,000 coinsurance and ded |
| | | |
| $0 no ded | $0 no ded | 50% no ded |
| $0 no ded | $0 no ded | N/A |
| $750 no ded | $750 no ded | 50% no ded |
| | | |
| $50 no ded | $0 after ded | 50% after ded |
| $100 no ded | $0 after ded | 50% after ded |
| $40 no ded | $0 after ded | Not covered |
| $150 after ded | $0 after ded | 50% after ded |
| $100 no ded | $0 after ded[9] | 50% after ded[9] |
| $80 no ded/$80 no ded | $0 after ded/$0 after ded[9] | 50% after ded/50% after ded[9] |
| | | |
| Subject to ded and $700/day[11] | $0 after ded | 50% after ded |
| 50% after ded | $0 after ded | 50% after ded |
| $500 after ded | $0 after ded | $0 after in-network ded |
| $100 no ded/$100 no ded | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| $250 no ded/$250 no ded | $0 after ded/$0 after ded | 50% after ded/50% after ded |
| $100 no ded | $0 after ded | 50% after ded |
| 50% after ded | $0 after ded | 50% after ded |
| $100 no ded | $0 after ded | 50% after ded |
| Subject to ded and $700/day[11] | $0 after ded | 50% after ded |
| | | |
| 30% up to $750 max after ded | $0 after ded | 50% after ded |
| 30% up to $750 max after ded | $0 after ded | 50% after ded |
| | | |
| $0 no ded | $0 after ded | 50% after ded |
| $0 no ded | $0 after ded | 50% after ded |
| | | |
| Integrated | Integrated | Integrated |
| $15 after ded[20] | $0 after ded[20] | 50% after ded |
| 50% after ded up to $500 max per fill[20, 21] | $0 after ded[20, 21] | 50% after ded[21] |
| 50% after ded up to $500 max per fill[20, 21] | $0 after ded[20, 21] | 50% after ded[21] |
| 50% after ded up to $1,000 max per fill[20, 21] | $0 after ded[20, 21] | Not covered |
| | | |
| $0 no ded | $0 no ded | Not covered |
| $0 no ded | $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Allowance up to $100 for frames or contact lenses, no ded; $150 frame allowance at Visionworks stores, no ded | Not covered |
| $0 | Integrated | Not covered |
| $0 | $0 no ded | Not covered |
| Copay varies | 0% after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

# B Bronze health plans

| Benefits per contract year[1] |
|---|
| Deductible, individual/family |
| Coinsurance |
| Out-of-pocket maximum, individual/family includes: |
| **Preventive services[8]** |
| Preventive care for adults and children |
| Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers |
| Preventive colonoscopy for colorectal cancer screening — Hospital-based |
| **Physician services** |
| Primary care office visit/retail clinic |
| Specialist office visit |
| Telemedicine† |
| Urgent care |
| Spinal manipulations (20 visits per year) |
| Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based |
| **Hospital/other medical services** |
| Inpatient hospital services (includes maternity) |
| Inpatient professional services (includes maternity) |
| Emergency room (not waived if admitted) |
| Routine Radiology — freestanding/hospital-based |
| MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based |
| Biotech/specialty injectables |
| Durable medical equipment/prosthetics |
| Mental health, serious mental illness, and substance abuse — outpatient |
| Mental health, serious mental illness, and substance abuse — inpatient |
| **Outpatient surgery** |
| Ambulatory surgical facility |
| Hospital-based |
| **Outpatient lab/pathology** |
| Freestanding |
| Hospital-based |
| **Prescription drugs[16, 17, 19, ‡]** |
| Rx deductible (individual/family) |
| Retail generic[18] |
| Retail preferred brand[18] |
| Retail non-preferred drug[18] |
| Specialty drug |
| **Vision and dental[23, 28, 32]** |
| Pediatric routine eye exam[24,25] and eyewear (glasses or contacts)[24,26] |
| Adult routine eye exam[25] |
| Adult eyewear (glasses or contacts)[27] |
| Pediatric dental deductible (per individual)[29] |
| Pediatric exams and cleanings[29, 30] |
| Pediatric basic, major, and orthodontia services[29, 31] |

**Preferred:** Copay plans | **Classic:** Coinsurance/deductible plans | **Secure:** Copay/deductible plans | **Essential:** HDHPs with integrated Rx deductible that are not HSA or HRA plans

| Personal Choice PPO Bronze HSA - O[4]<br>$5,200/50% | |
|---|---|
| **You pay in-network** | **You pay out-of-network[7]** |
| $5,200/$10,400 | $10,000/$20,000 |
| 50% | 50% |
| $6,650/$13,300<br>coinsurance, copays, and ded | $20,000/$40,000<br>coinsurance and ded |
| | |
| $0 no ded | 50% no ded |
| $0 no ded | N/A |
| $750 no ded | 50% no ded |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | Not covered |
| 50% after ded | 50% after ded |
| 50% after ded[9] | 50% after ded[9] |
| 50% after ded/50% after ded[9] | 50% after ded/50% after ded[9] |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after in-network ded |
| 50% after ded/50% after ded | 50% after ded/50% after ded |
| 50% after ded/50% after ded | 50% after ded/50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| | |
| 50% after ded | 50% after ded |
| 50% after ded | 50% after ded |
| | |
| Integrated | Integrated |
| $7 after ded[20] | 50% after ded |
| $50 after ded[20, 21] | 50% after ded[21] |
| $100 after ded[20, 21] | 50% after ded[21] |
| 50% after ded up to $1,000 max per fill[20, 21] | Not covered |
| | |
| $0 no ded | Not covered |
| $0 no ded | Not covered |
| Allowance up to $100 for frames or contact lenses, no ded;<br>$150 frame allowance at Visionworks stores, no ded | Not covered |
| Integrated | Not covered |
| $0 no ded | Not covered |
| 50% after ded | Not covered |

Footnotes begin on page 45 | ded = Deductible

# What's not covered

- Services not medically necessary
- Services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-employee recipients
- Music therapy, equestrian therapy, and hippotherapy
- Sex therapy or other forms of counseling for treatment of sexual dysfunction when performed by a non-licensed sex therapist
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prosthesis, including wigs intended to replace hair loss
- Alternative therapies/complementary medicine such as acupuncture
- Routine physical exams for non-preventive 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
- Bariatric or obesity surgery
- Outpatient private duty nursing

## Benefits that require preapproval

Additional approval from Independence may be required before your employees may receive certain tests, procedures, and medications. When your employees need services that require preapproval, their physician or provider contacts the Clinical Services team and submits information to support the request for services. The Clinical Services team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The Clinical Services team will notify your employee's 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, your employee and his or her physician/provider are notified in writing of the decision. Employees or a provider acting on their behalf may appeal the decision. At any time during the evaluation process or the appeal, the provider or your employee may submit additional information to support the request.

## Additional benefits and exclusions

The information in this brochure represents only a partial listing of benefits and exclusions of the plans. Benefits and exclusions may be further defined by medical policy. The managed care plan may not cover all your health care expenses. Read your contract, member handbook, or benefits booklet carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (1-800-275-2583).

Information in this brochure is current at the time of publication and is subject to change.

## Additional information

Your broker, consultant, or Independence Blue Cross account executive can provide information about the following upon request:

- Factors that may affect changes in premium rates*
- Renewability of coverage
- Description of the geographic areas served by our HMO plans
- Benefits and premiums for all the health benefit plans for which you qualify

* Independence reserves the right to change premium rates.

# Important plan details

## Medical

1. Certain plan benefits may be enhanced to comply with Affordable Care Act regulations. Eligible dependent children are covered to age 26.

2. Embedded Deductible: Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. Once an individual meets the individual deductible amount, claims for that individual will pay. Once the family deductible is met, claims for all individuals will pay. Once an individual meets the individual out-of-pocket maximum, benefits for that individual are covered in full. Once the family out-of-pocket maximum is met, benefits for all family members are covered in full. Individual deductible and out-of-pocket maximum apply when an individual is enrolled without dependents.

3. Embedded Out-of-Pocket Maximum: Family out-of-pocket maximum applies when an individual and one or more dependents are enrolled. 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 out-of-pocket maximum applies only when an individual is enrolled without dependents.

4. Aggregate Deductible: Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. The full family deductible must be met by one or several family members before claims are eligible to pay; however, no family member will contribute more than the individual out-of-pocket maximum amount. Once an individual in the family has met the single out-of-pocket maximum, benefits for that member are covered in full. Benefits for all family members are covered in full once the family out-of-pocket maximum is met. If an individual is enrolled without dependents, individual deductible and out-of-pocket maximum apply.

5. To receive maximum benefits, services must be provided by a Keystone Health Plan East participating provider. This is a highlight of available benefits. The benefits and exclusions for in-network and out-of-network care are not the same. All benefits are provided in accordance with the HMO group contract and out-of-network benefits booklet/certificate.

6. There are no out-of-network services available except for emergency services, and generic, preferred brand, and non-preferred prescription drugs obtained at a retail pharmacy.

7. Out-of-network providers may bill you for differences between the Plan allowance, which is the amount paid by Independence, and the actual charge of the provider. This amount may be significant. Claims payments for out-of-network providers are based on the lesser of the Medicare Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, payment is based on the lesser of the Independence applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is based on 50 percent of the actual charge of the provider with the exception of inpatient facility services. For inpatient facility covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is determined by Independence's fee schedule for the closest analogous covered service.

   It is important to note that all percentages for out-of-network services are percentage of the plan allowance, not the actual charge of the provider.

8. Age and frequency schedules may apply. For preventive colonoscopy for colorectal cancer screening, your cost-share may vary depending on where you receive the service.

9. For PPO plans, visit limits are combined in-and out-of-network.

10. Referral required from primary care physician.

11. Amount shown reflects the copayment per day. There is a maximum of five copayments per admission.

12. For Keystone HMO Proactive plans, the out-of-pocket maximum for Tiers 1, 2, and 3 are combined.

13. For Keystone HMO Proactive plans, all in-network retail clinics are assigned to Tier 1, with the exception of Walgreens Healthcare Clinic and Rite Aid RediClinic, which are assigned to Tier 3.

14. For Keystone HMO Proactive plans, if admitted to an in-network hospital from the emergency room, the out-of-pocket costs for inpatient hospital will apply based on the tier of the in-network hospital. If admitted to an out-of-network hospital following an emergency room admission, the Tier 3 in-network level of benefits will apply. Non-participating providers for Emergency Services will be covered at the Tier 3 level of benefits.

15. For Keystone HMO Silver Proactive plan, deductible is combined for Tiers 2 and 3.

## Prescription drugs

16. Prescription drug benefits are administered by FutureScripts, an independent company providing pharmacy benefit management services.

17. No cost-sharing is required at participating retail and mail order pharmacies for certain designated preventive drugs, prescription and over-the-counter (with a doctor's prescription).

18. Out-of-network benefits apply to prescriptions filled at non-participating pharmacies and the member must pay the full retail price for their prescription then file a paper claim for reimbursement. Member should refer to their benefits booklet to determine the out-of-network coverage for their plan.

19. Mail-order coverage is available for all prescription drug plans. The FutureScripts Mail-order service is a convenient and cost-effective way to order up to a 90-day supply of maintenance or long-term medication for delivery to a home, office, or location of choice.

20. Select plans utilize the FutureScripts Preferred Pharmacy Network, a subset of the national retail pharmacy network. It includes over 50,000 pharmacies, including most major chains and local pharmacies except Walgreens and Rite Aid.

21. 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 chooses to purchase 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.

22. Certain designated generic drugs are available at participating retail and mail-order pharmacies for reduced member cost-sharing ($4 retail/$8 mail order).

‡ For all plans, member pays cost share per each fill unless out-of-pocket maximum has been met.

## Additional benefits

23. Independence vision benefits are administered by Davis Vision, an independent company.

24. Pediatric vision benefits expire at the end of the month in which the child turns 19. Pediatric vision covers Davis Collection glasses or contact lenses in full at Davis Vision providers.

25. One eye exam per calendar year period.

26. Davis Collection pediatric contact lenses or spectacle lenses covered at no extra cost include: single vision, lined bifocal, lined trifocal, or lenticular lenses. For frames to be covered in full, choose from Davis Vision's Pediatric Frame Selection (available at most independent participating providers and at Visionworks retail centers, a national optical chain). Eyewear (glasses or contact lenses) is covered once per calendar year.

27. Up to $100 frame or contact lenses allowance at participating providers, or up to a $150 frame allowance at Visionworks retail centers. The high-deductible health plan deductible does not apply to the vision benefit.

28. Independence dental benefits are administered by United Concordia, an independent company.

29. Pediatric dental benefits are covered until the end of the contract year in which the member turns 19.

30. Pediatric dental benefit: One exam and one cleaning every six months per contract year.

31. Pediatric dental benefit: Only medically necessary orthodontia is covered.

32. Your Independence account executive or broker can provide you with descriptions of covered pediatric dental services and member cost-sharing.

† For telemedicine, members are responsible for a $40 fee per occurrence. Independence telemedicine benefits are administered by MDLive, an independent company.

The member has the right to receive health care services without discrimination based on race, ethnicity, age, mental or physical disability, genetic information, color, religion, gender, sexual orientation, national origin, or source of payment.

# Underwriting guidelines summary[1]

## Maximum product offerings[1]

- Small employers are allowed up to three packaged plans which include medical, prescription drug, vision (adult and pediatric) and pediatric dental benefits.
- If a group is offering a PPO plan for out-of-area enrollment, the PPO benefit level must be equivalent to the benefit plans offered to the in-area employees. Group offerings may not exceed three plans, including a plan for out-of-area PPO coverage.

## Participation requirements[1]

- Small employers must have 70 percent participation, which includes all product lines.
- Independence will count waivers in the eligibility calculations. Credit is given for those eligible employees who opt out because they have coverage through a spouse, as an eligible dependent to 26, or employees enrolled in Veteran coverage, Medicare, Medicaid, or any other government-issued coverage.
- Retiree-only groups will not be accepted. For groups covering retirees, 100 percent participation will be required for retired employees. The group must consist of a minimum of 70 percent active employees.

## Employer contribution requirement[1]

- For contributory plan offerings, you must contribute a minimum of 25 percent of the calculated gross monthly premium.

## Off-anniversary benefit change

- Upgrades and downgrades will only be allowed on anniversary.

## High-deductible health plan funding limitation

- Per Affordable Care Act regulations, employers should not fund more or less than the federally mandated standards for funding employee deductibles.
- The high-deductible plan design selected will specify the funding requirement. Please refer to each plan design for specific funding requirements.

## Submission guidelines

- All offerings are subject to final underwriting review and acceptance.

Additional guidelines and policies may apply. This document is for informational purposes only and is not intended to be all inclusive.

1. As permitted by the state and federal laws and regulations.

## Spending account funding requirements

When a Blue Solution plan includes an HSA or HRA, the required employer contribution to the HSA or HRA is listed as a percentage of the deductible to the right of the plan name (i.e. 50 or 25 percent). To comply with federal requirements, the employer HSA and/or HRA contribution must match this percentage. Contributions should not be less than or more than this percentage. Examples:

| | Personal Choice PPO Platinum HSA – 50 $1,600/100% | Personal Choice PPO Gold HRA – 25 $2,900/100% |
|---|---|---|
| Contribution requirement | 50% of deductible | 25% of deductible |
| Plan deductible (Individual/family) | $1,600/$3,200 | $2,900/$5,800 |
| Employer contribution amount | $800/$1,600 | $725/$1,450 |

# Do you know the power of Blue?

BLUE PLANS COVER

**106**

**MILLION**

MEMBERS

BLUE PLANS INCLUDE

**THE LARGEST**

PROVIDER

**NETWORK**

NATIONWIDE

**96%**

HOSPITALS

**93%**

DOCTORS

Independence

# Additional Workplace Benefits

# Affordable options to complete your benefits package

## Attract and retain the best employees with a benefits package that includes adult dental, supplemental and international health insurance, and a college tuition benefit.

### Promote good oral health with adult dental coverage

Add cost-effective dental coverage for enrolled members age 19 and older to your benefits package. Our adult dental plans are administered by United Concordia and encourage prevention, early diagnosis, and treatment.

- PPO and DHMO options cover diagnostic and preventive services like exams, cleanings, and X-rays in full, with no benefit waiting periods.
- Our PPO plans offer an extensive network of over 62,000 unique dentists at over 244,000 access points nationwide.
- Our Adult Dental Premier PPO with Preventive Incentive plan encourages members to get preventive care. The amount the plan pays for preventive services is not subtracted from the plan's $1,000 annual maximum, leaving members the full amount to put toward services like fillings or crowns.

### Helping members maximize their dental dollars

With our PPO plans, members can visit any provider, but they pay less out of pocket by choosing in-network providers. Provider discounts also help them save.


Members save an average of 36% on covered services

Many participating providers offer discounts for non-covered services

# Compare our adult dental options

## PPO:

- Members can choose any provider but pay less by using providers in the Concordia Advantage network
- No referrals required for treatment from specialists

## DHMO:

- Available as a rider on Keystone HMO and DPOS plans
- Members are required to choose a Primary Dental Office and need referrals for treatment from specialists

| | Adult Dental Preventive PPO $ | Adult Dental Preferred PPO $$ |
|---|---|---|
| Dental Deductible | $0 | Individual: $50 Family: $150 |
| Annual Maximum Dental Benefit Per Insured Member | $1,000 | $1,000 |
| **Benefits** | **Member Pays[1]** | **Member Pays[1]** |
| Oral Evaluations (Exams) | $0 | $0 |
| Radiographs (X-Rays) | $0 | $0 |
| Prophylaxis (Cleanings) | $0 | $0 |
| Palliative Treatment (Emergency) | Not covered | $0 |
| Amalgam Restorations (Metal fillings) | Not covered | 50% after ded |
| Resin-Based Composite Restorations (White fillings — Anterior teeth only) | Not covered | 50% after ded |
| Crowns, Inlays, Onlays | Not covered | Not covered |
| Crown Repair | Not covered | 50% after ded |
| Endodontic Therapy (Root canals, etc.) | Not covered | 50% after ded |
| Other Endodontic Services | Not covered | 50% after ded |
| Surgical Periodontics | Not covered | 50% after ded |
| Non-Surgical Periodontics | Not covered | 50% after ded |
| Periodontal Maintenance | Not covered | 50% after ded |
| Prosthetics (Complete or Fixed Partial Dentures) | Not covered | Not covered |
| Adjustments and Repairs of Prosthetics | Not covered | 50% after ded |
| Other Prosthetic Services | Not covered | Not covered |
| Simple Extractions | Not covered | 50% after ded |
| Surgical Extractions | Not covered | 50% after ded |
| Oral Surgery | Not covered | 50% after ded |
| General Anesthesia, Nitrous Oxide, and/or IV Sedation | Not covered | 50% after ded |
| Consultations | Not covered | $0 |

Adult dental benefits are current at the time of publication and are subject to change.

| Adult Dental Premier PPO with Preventive Incentive $$$ | Adult DHMO[2] |
|---|---|
| Individual: $50 Family: $150 | $0 |
| $1,000 | None |
| **Member Pays[1]** | **Member Pays** |
| $0[3] | $0 |
| $0[3] | $0 |
| $0[3] | $0 |
| $0[3] | $0 |
| 20% after ded | $13 – $23 |
| 20% after ded | $15 – $25 |
| 50% after ded | $26 – $361 |
| 20% after ded | $0 – $92 |
| 20% after ded | $26 – $284 |
| 20% after ded | $0 – $84 |
| 20% after ded | $0 – $205 |
| 20% after ded | $17 – $100 |
| 20% after ded | $25 – $32 |
| 50% after ded | $232 – $433 |
| 20% after ded | $10 – $242 |
| 50% after ded | $30 – $377 |
| 20% after ded | $10 – $16 |
| 20% after ded | $51 – $120 |
| 20% after ded | $26 – $97 |
| 20% after ded | Included[4] |
| $0 | $0 – $19 |

1. Coverage is based on the Maximum Allowable Charge (MAC) for the specific covered service. Participating dentists accept contracted MACs as payment in full. Non-participating dentists do not limit their charges and may bill you for the difference between their charge and the benefit paid by the plan.
2. The Adult DHMO rider is available for HMO and DPOS plans. Members must select a Primary Dental Office (PDO), and referrals are required for specialist services.
3. Included in the Preventive Incentive. The amount paid by the plan (benefit) does not count toward the member's annual benefit maximum.
4. Benefit is limited to covered oral surgical services for impacted teeth.

Refer to the benefit booklet for limitations and exclusions.

# Give your employees peace of mind and protect their wealth

We've teamed up with industry leaders to help you protect the health and wealth of your employees with affordable products that complement our medical plans.

## Guardian® supplemental insurance — A financial safety net for unexpected illness or injury

Additional out-of-pocket costs can make a difficult situation such as an illness or injury even more stressful. Guardian is a trusted name with more than 150 years in the life insurance business.

### Life

- Provides money for an employee's family in the event of his/her death
- Coverage is guaranteed, regardless of health history
- Customize coverage with Basic Life, Voluntary Life, and Accidental Death & Dismemberment policies

### Disability

- Replaces a portion of income when a person is unable to work
- Offers an enhanced rehabilitation benefit, including dependent care reimbursement
- Choose from Short- and Long-Term Disability (STD/LTD) and Administrative Services Only STD

### Accident, critical illness, cancer, and hospital indemnity

- Provides financial assistance with medical and non-medical expenses in the case of an accident or serious illness
- All coverage options offer a lump sum payment
- Option for members to increase accident insurance benefits by 20 percent for a child injured while playing organized sports

Ask your broker, consultant, or Independence account executive about adding these products and services to your medical benefits.

## International health insurance — High-quality care is never far away

GeoBlue offers health plans for single trips, multiple trips, and expats — giving your employees and their families confidence to travel and work internationally. Most plans cost just a few dollars per travel day, and discounts are available for groups of five or more.

### Best-in-class providers

Access to English-speaking, Western-trained physicians in over 190 countries

### Comprehensive coverage

Hospitalization, doctor visits, and prescriptions are covered

### Emergency coverage

Medical evacuation and other emergency services are covered

### Stress-free service

Billing for care is cashless and paperless

### 24/7 concierge support

VIP assistance for scheduling appointments and managing care

With tools available on the GeoBlue app, members can find providers and manage care anywhere in the world quickly.

## An easy way to make higher education more affordable

Give employees the option to help eligible family members pay for their undergraduate education — at no cost to them — through the College Tuition Benefit®, an independent company.

- Employees can accrue SAGE Scholars Tuition Rewards® to use toward tuition at 375+ private colleges and universities in 46 states
- 1 Tuition Rewards point = $1 reduction in full tuition
- 2,500 points for enrolling and 2,000 points each additional year
- Rewards can be allocated to children, grandchildren, nieces, and nephews
- No cap to accumulating rewards; apply up to one year of tuition per family member

FutureScripts is an independent company providing pharmacy benefits management services for Independence Blue Cross.

Independence vision benefits are administered by Davis Vision, an independent company. An affiliate of Independence has a financial interest in Visionworks.

Independence Blue Cross dental benefits are administered by United Concordia Companies, Inc., an independent company.

Guardian Group Accident Insurance, Cancer Insurance, Critical Illness Insurance, Hospital Indemnity Insurance, Life Insurance, and Disability Insurance are underwritten by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. These products provide limited benefits. Plan documents are the final arbiter of coverage. Accident Insurance Policy Form #GP-1-AC-IC-12 Cancer Insurance Policy Form #GP-1-CAN-IC-12 Critical Illness Policy Form #GC-CI-11 Hospital Indemnity Policy Form #GP-1-HI-15 Term Life Insurance Policy Form #GC-Life-15-1.0 AD&D Policy Form #GC-ADD-15-1.0 Voluntary Term Life Policy Form #GP-1-R-ADCL1-00 Short Term Disability Form et al.; #GP-1-STD-15-1.0 Long Term Disability Form #GP-1-LTD-15-1.0 et al. 2017-42586 (exp.6/19).

International health insurance is provided by Blue Cross Global, a brand owned by the Blue Cross Blue Shield Association, a national federation of 36 independent, community-based and locally-operated Blue Cross and Blue Shield Companies. GeoBlue is the trade name of Worldwide Insurance Services, LLC (Worldwide Services Insurance Agency, LLC in California and New York), an independent licensee of Blue Cross Blue Shield Association and is made available in cooperation with Blue Cross and Blue Shield Companies in select service areas.

The Tuition Rewards program is provided by College Tuition Benefit. Tuition Rewards® Points represent a "guaranteed minimum scholarship," redeemable for discounts on undergraduate tuition at participating four-year private colleges and universities, starting with the freshman year. Points must be submitted at time of application. Participating colleges reserve the right to include Tuition Rewards® as part of the financial aid package. Tuition Rewards® are limited to a maximum per student of up to one year's tuition, spread evenly over 4 years, or as contractually agreed. Tuition Rewards® are remitted solely as a reduction to the participating college's full tuition bill – NOT awarded in cash.

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