Independence

2019 Blue Solutions®

Affordable, fully ACA-compliant coverage for small employers

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

Independence

Independence Blue Cross is committed to making health care effective, affordable, and simple.

Access to the most doctors and hospitals nationwide

Programs to help members achieve well-being

Benefits that go beyond medical

Tools to keep you and members informed

Your guide to our 2019 Blue Solutions portfolio

We're making health care work better for you with more in every plan

There's an advantage to choosing Blue Solutions® health plans from Independence Blue Cross — it's giving your employees and their families affordable access to the nation's largest provider network and comprehensive benefits to help them live their healthiest life.

Protect employees' health

For one monthly premium payment, our fully ACA-compliant Blue Solutions health insurance plans offer coverage and support members can count on to help them get high-quality, cost-effective care:

- 100% coverage for preventive care, like immunizations and screenings
- Affordable, convenient alternatives to the ER for non-emergencies, including telemedicine visits
- Coverage for diagnosis and treatment of Autism Spectrum Disorders* and for acupuncture as an alternative therapy for limited conditions

- Prescription drug coverage, with access to an online drug search and pricing tool
- Vision benefits for adults and children, with enhanced benefits for adult eyewear
- Pediatric dental benefits that include in-network dental exams and cleanings covered in full every six months

- 24/7 access to a registered nurse Health Coach for personal support with health-related questions and concerns

*Benefit covered for members under 21 years of age.

A total benefits solution to help lower costs

Financial stress can take a toll on physical and mental health. We offer value-added benefits and tools that help give your employees and their families the peace of mind that comes from being able to make their hard-earned money go further.

Protect employees' wealth

- New Care Cost Estimator tool helps members estimate and plan for out-of-pocket costs before they receive care
- Reimbursements for gym workouts, weight management, and tobacco cessation programs
- Discounts and savings on health and well-being products and services, like wearable fitness trackers
- Emails and text messages with plan information and education, health care reminders, and savings opportunities
- College Tuition Benefit® lets employees earn Tuition Rewards® to help pay for higher education for eligible family members

Industry leading products to complete your benefits package

You can also complement our health plans with benefits that offer coverage and protection beyond medical, for a holistic approach to help reduce long-term costs.

Standalone dental plans

- **Adult plans** — 3 PPO plans, 1 DHMO plan
- **New family plans** — 3 PPO family plans, with two that offer cosmetic orthodontia benefits up to age 19

Guardian® supplemental insurance

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

GeoBlue international health insurance

- Single trip
- Multiple trip
- Expat coverage

Choose from four health plan types to meet your needs and budget

No matter what size your business is, you can choose up to three health plans to fit your budget and ensure employees and their families are covered, even if they live outside of our Philadelphia five-county service area.

	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, physical/occupational therapy, and acupuncture. For lab work, members should use the designated site selected by their PCP for the lowest out-of-pocket costs.

Manage health benefits with convenient online employer tools

The tools you need to administer your health benefits efficiently are available at one secure website — ibxpress.com — along with marketing and well-being materials to engage and educate your employees.

Manage your account

- Complete enrollment transactions
- View membership reports
- Administer spending accounts

Pay by e-Bill

- View and pay current and prior invoices
- Review billing and invoice payment history
- Get billing reminders by email

Promote well-being

- Learn about a holistic approach to employee wellness
- Get information to plan and implement a worksite well-being program
- Use free resources like our monthly well-being newsletter to engage employees

Empowering every member to save money when they need care

All Blue Solutions plans give members the option to maximize their benefits and save money on common health care services — in some cases hundreds of dollars.

Choosing the most cost-effective location to receive care

Members have the choice to lower out-of-pocket costs based on the location where they receive care for the following services:

Preventive colonoscopy

- $0 preventive colonoscopy when performed by non-hospital based Preventive Plus providers and GI professionals[1]
- Benefit included in all plans

Outpatient surgery

- Lower cost-sharing for services[2] at in-network ambulatory surgical centers (ASCs)
- Benefit included in most non-HSA-qualified plans

Biotech/specialty injectables and infusion

- Lower cost-sharing applies when a drug is administered in the home or office. Higher cost-sharing applies in an outpatient setting
- Benefit included in many non-HSA qualified and non-HRA plans

Outpatient labs

- **HMO and Direct POS plans:** 100% coverage for in-network services when using PCP's designated lab
- **Non-HSA and non-HRA plans:** $0 cost-sharing at freestanding in-network labs

PT/OT and radiology

- Lower cost-sharing at office-based providers or freestanding sites; higher at hospital-based sites[3]
- Benefit included in non-HSA-qualified PPO plans

Using telemedicine to avoid the ER when it's not an emergency

If their own doctor isn't available, members have the option to use telemedicine from MDLIVE® for 24/7 access to U.S. board-certified doctors by phone or online or mobile video. It's more convenient and less expensive than visiting the ER for non-emergencies such as:

- Colds and flu
- Allergies
- Ear and sinus infections
- Pink eye
- Rashes
- Joint aches and pains

Refer to the plan charts beginning on page 22 for cost-sharing amounts.

1. Out-of-pocket costs can be up to $750 by choosing non-Preventive Plus providers and professionals. Age and frequency guidelines apply to preventive care, such as colonoscopies. 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. 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. Diagnostic colonoscopies are subject to the cost-sharing provision of the member's outpatient surgery benefit.
2. Common outpatient surgical procedures performed at ASCs include tonsil removal, hernia repairs, and cataract surgeries.
3. The benefit applies to physical and occupational therapy and routine and complex radiology.

Keystone HMO Proactive tiered network plans offer more choice and savings

Our innovative Keystone HMO Proactive plans are a popular choice for small employers because they give members access to our full Keystone HMO network at a lower premium and the choice to lower out-of-pocket costs when they need care.

How tiered network plans work

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.

Tier 1 – Preferred $

Tier 2 – Enhanced $$

Tier 3 – Standard $$$

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

Specialty care savings with Blue Distinction Center+ hospitals

Blue Distinction Center+ (BDC+) hospitals 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

Tier 1 – Preferred $

Pennsylvania

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

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

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

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

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

Philadelphia
- Albert Einstein Medical Center
- Albert Einstein Medical Center — Germantown Campus
- Aria Health — Frankford Campus
- Aria Health — Torresdale Campus
- Hahnemann University Hospital
- Jeanes Hospital
- Roxborough Memorial Hospital
- Tower Health — Chestnut Hill 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
- St. Joseph Medical Center
- Tower Health — Reading Hospital and Medical Center

Bucks
- St. Mary Medical Center

Chester
- Main Line Health — Paoli Hospital

Delaware
- Main Line Health — Riddle Hospital

Lancaster
- Ephrata Community Hospital
- Lancaster General Hospital

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

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

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

New Jersey

Burlington
- Virtua Marlton Hospital
- Virtua Memorial Hospital

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

Hunterdon
- Hunterdon Medical Center

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

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

Blue Distinction® Center+ Specialties

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

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

Prescription drug benefits encourage safe, effective, and affordable use

Every Blue Solutions plan includes prescription drug coverage administered by FutureScripts®, with multiple ways to help lower costs. All plans use the Value Formulary, a comprehensive list of generic, brand, and specialty drugs, to drive more cost-effective utilization.

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 no more than $4 for certain generics at participating retail pharmacies

Specialty Drug Cost-Share

- Included in all plans — specialty drugs treat complex or chronic diseases and require special handling, administration, and monitoring

Members can use BriovaRx® for:

- Best pricing, free shipping, and supplies
- Support from experienced specialty pharmacists and nurses
- Guidance on treatment, administration, and side effects
- Access to BriovaLive® award-winning video consultation

EASY TO USE
ONLINE TOOLS

Find a network pharmacy, get drug prices, review claims, and submit mail-order requests at **ibxpress.com**

VALUE FORMULARY

Encourages members to consider generic and lower-cost brand medications[1]

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 BroviaRx®

Members receive 24/7 support from highly experienced pharmacists.
To enroll, members call **1-855-4BRIOVA**

OVER 68,000 PHARMACIES NATIONWIDE

All plans offer access to an extensive network of retail and independent pharmacies[2]

1. With the Value Formulary, drugs may be not covered when there are alternatives that can be used to treat the same condition at a lower cost.
2. Some plans use the Preferred Pharmacy network, which includes more than 50,000 pharmacies. For these plans, 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 and dental coverage help keep members healthier to lower costs

Adult vision benefits, plus vision and dental benefits for children up to age 19, are included in every Blue Solutions plan — helping members better manage their total health.

Vision benefits for adults and children[1], administered by Davis Vision®

- One routine in-network eye exam is covered in full per calendar year. Routine eye exams can protect a person's sight and can help detect more serious medical conditions such as high blood pressure and diabetes.
- All plans help members save two ways with enhanced allowances for adult eyewear: up to $130 for frames or contacts at participating Davis Vision providers and up to $180 for frames at Visionworks stores.

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[2] 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

72,000 Points of Access

Extensive network of providers and retailers, including Visionworks locations

1. Adult and pediatric vision benefits are not subject to a deductible.
2. 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

All plans include in-network dental benefits[3] for enrolled members up to age 19 to help kids get on the road to good oral health.

Personal Choice® PPO (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 (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

3. 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 your 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 Solution and HRA

For employers

- Tax advantages and no administrative fees*
- Flexibility to choose plans that fit your budget
- Easy account maintenance and online reporting
- Convenient funding methods

For employees

- Tax advantages and no monthly account fee*
- Easy access through ibxpress.com
- Integration of spending accounts and health claims
- Streamlined payments including debit card

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 plan
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 53 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.

Advantages of our BlueSaver spending accounts

We offer full integration with our qualified HDHPs for seamless account management, a single debit card to pay for eligible expenses, and support from specialized customer service and banking teams.

Health spending account (HSA)

- Multiple contribution options to fund employee HSAs
- Quick account funding
- Dedicated banking support

Health reimbursement account (HRA)*

- Medical claim balances automatically flow to the HRA for payment
- Provider pay or member reimbursement option
- Optional no-fee pharmacy only debit card

Easy spending account administration and employer toolkit at ibxpress.com

Our employer portal at **ibxpress.com** is your one-stop shop for tools to manage spending account contributions, billing, and reporting. You can also access a library of spending account resources to support account management and help you engage members including:

- Account contribution and billing guides
- Spending account promotional materials
- Member open enrollment materials and educational HSA videos

*Because an HRA offers employer-owned funds, there is greater flexibility in what expenses are covered, provided they are considered qualified medical and dental expenses. Refer to IRS Publication 502 for a complete list of qualified medical and dental expenses.

Engaging members to improve their 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 benefits decision, we empower members to 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]

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

Members have a one-stop benefits management destination

At home or on the go, members can access benefit, cost, and spending information, easy-to-use tools, and personalized digital content — all in the palm of their hand at ibxpress.com and on the IBX app.

NEW: Care Cost Estimator

- New tool estimates out-of-pocket costs for a wide range of common services based on a member's plan
- Compares costs by provider in the plan's network
- Results show out-of-pocket costs like coinsurance and deductibles based on the member's benefits and their year-to-date spend

Find a Doctor

- Find doctors and hospitals by name or specialty and zip code
- Search for pharmacies, walk-in clinics, and urgent care centers
- Choose or change a PCP

Price a Drug

- Search a drug by brand or generic name
- View and print drug information like description and common uses
- Compare savings for retail pharmacies by zip code and for mail order

Driving higher member engagement for powerful results

To ensure members are taking advantage of benefits, tools, and well-being programs, we connect with them regularly through customized email and IBX Wire® text messages. These messages drive members directly to tools and resources to take action based on message content including:

- Benefits education throughout their plan year
- Reminders about tests and screenings
- Lower-cost options for care
- Healthy lifestyle savings opportunities

Digitally engaged members are making healthy choices

We know higher member engagement works. Check out these compelling statistics that illustrate the behavior of members who are engaged in our messaging channels compared to those who aren't connected.

11% INCREASE IN COMPLIANCE WITH NECESSARY TESTS AND SCREENINGS

20% INCREASE IN SWITCH RATE FROM BRAND TO GENERIC DRUGS

45% MORE CALLS TO HEALTH COACHES

College Tuition Benefit® helps make higher education more affordable

There is a powerful recruitment and retention tool that's now included in all Blue Solutions plans — the College Tuition Benefit. It lets your employees earn Tuition Rewards® to help offset the rising costs of higher education for eligible family members, at no cost to them.

How the College Tuition Benefit works

Employees can accrue SAGE Scholars Tuition Rewards® to use toward tuition at almost 400 private colleges and universities in 46 states:

- 1 Tuition Reward point = $1 reduction in full tuition
- Members earn 2,000 points for enrolling in the program; 500 points are awarded specifically to each eligible child registered
  - 2,000 points are awarded to the subscriber annually the month following the plan's renewal
  - 2,500 bonus points are awarded to the subscriber in the month following the health plan's third renewal, for a total of 4,500 points in year four
- No cap to accumulating rewards; apply up to one year of tuition per family member
- Rewards can be allocated to children, stepchildren, grandchildren, nieces, and nephews

Visit **ibx.collegetuitionbenefit.com** to view a complete list of participating schools.

College Tuition Benefit is an independent company.

Additional Workplace Benefits

New family dental plans give members more ways to save

Our cost-effective standalone dental plans are administered by United Concordia, a national dental insurance leader, and offer the quality, value, and flexibility that you expect from Independence.

Standalone dental plan benefits

All standalone dental plans

- 100 percent coverage for preventive care, like exams, cleanings, and X-rays, with no benefit waiting periods
- Access to an extensive, nationwide provider network
- For PPO Plans with a Preventive Incentive, the amount these plans pay for preventive exams, cleanings, and X-rays doesn't count towards the annual maximum benefit, allowing members to apply the annual maximum amount to other, more costly services

NEW: Family dental plans

- Cover preventive, basic, and major services for children and adults, with no waiting periods
- Include out-of-network pediatric benefits — our medical plans only cover in-network services for dependents up to age 19
- Members with HDHPs can access benefits for pediatric basic, major, and orthodontia services right away, without waiting to reach their medical deductible first

Two family plans offer cosmetic pediatric orthodontia benefits

The average cost of braces for children is between $3,000 and $7,000. Our Premier and Deluxe Family PPO plans provide 50% cosmetic orthodontia coverage, up to a $1,000 lifetime maximum, for dependents up to age 19 to help make it more affordable to maintain a healthy smile.

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.

With United Concordia, members save an average of 54% on covered services.

Many participating providers offer discounts for non-covered services, including those that exceed the plan's annual maximum benefit.

99% of dental claims are paid within 30 days.

Compare our standalone dental options

Family PPO dental plans:

- Members can visit any dental provider but pay less by choosing providers in the Concordia Advantage national network, with more than 63,000 dentists and 246,000 points of access across the country.
- Premier and Deluxe family plans offer cosmetic orthodontia benefits for children up to age 19.
- No referrals are needed.

Plan benefits	Preferred Family PPO[3]	Premier Family PPO[3]	Deluxe Family PPO[3]
Dental deductible	$50 Individual, $150 Family	$50 Individual, $150 Family	$50 Individual, $150 Family
Annual maximum benefit (per member)	$1,000	$1,000	$1,000
Preventive services	**Member pays**	**Member pays**	**Member pays**
Exams/Evaluations	$0[1]	$0[1,4]	$0[1,4]
Cleanings	$0[1]	$0[1,4]	$0[1,4]
X-rays	$0[1]	$0[1,4]	$0[1,4]
Emergency/Palliative treatment	$0[1]	$0[1,4]	$0[1,4]
Fluoride treatments[1]	Up to age 19: $0 Age 19+: Not covered (discount may apply)	Up to age 19: $0 Age 19+: Not covered (discount may apply)	Up to age 19: $0 Age 19+: Not covered (discount may apply)
Sealants[1]	Up to age 19: $0 Age 19+: Not covered (discount may apply)	Up to age 19: $0 Age 19+: Not covered (discount may apply)	Up to age 19: $0 Age 19+: Not covered (discount may apply)
Space maintainers[2]	Up to age 19: 50% after ded Age 19+: Not covered (discount may apply)	Up to age 19: 20% after ded Age 19+: Not covered (discount may apply)	Up to age 19: 10% after ded Age 19+: Not covered (discount may apply)
Basic services	**Member pays**	**Member pays**	**Member pays**
Fillings[2] (Amalgam restorations – metal; Resin-based composite restorations – white)	50%	20%	10%
Simple and surgical extractions[2]	50%	20%	10%
Crown and denture repair[2]	50%	20%	10%
Root canals[2] (Endodontic therapy and services)	50%	20%	10%
Surgical and non-surgical periodontics and maintenance[2]	50%	20%	10%
Oral surgery[2]	50%	20%	10%
General anesthesia, nitrous oxide, and/or IV sedation[2,5]	50%	20%	10%
Major services	**Member pays**	**Member pays**	**Member pays**
Crowns, inlays, onlays[2]	Not covered (discount may apply)	50%	40%
Complete or fixed partial dentures[2] (prosthetics)	Not covered (discount may apply)	50%	40%
Implants	Not covered	Not covered	Not covered
Orthodontia	**Member pays**	**Member pays**	**Member pays**
Cosmetic orthodontia[1]	Not covered	Up to age 19: 50% Age 19+: Not covered $1,000 lifetime max for members up to age 19	Up to age 19: 50% Age 19+: Not covered $1,000 lifetime max for members up to age 19

Adult dental benefits are current at the time of publication and are subject to change. Refer to the benefit booklet for limitations and exclusions.

1. No deductible
2. Coinsurance after deductible
3. 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.
4. Included in the Preventive Incentive. The amount paid by the plan (benefit) does not count toward the member's annual benefit maximum.

Adult only PPO dental plans:

- For members age 19 and older, these plans complement embedded pediatric dental benefits.
- Members can visit any dental provider but save by using the Concordia Advantage network, with more than 63,000 dentists and 246,000 points of access across the country.
- No referrals are needed.

Adult DHMO plan:

- Available to purchase with Keystone HMO and DPOS medical plans only.
- Fixed copays help members predict out of pocket costs.

Adult Preventive PPO[3]	Adult Preferred PPO[3]	Adult Premier PPO[3]	Adult DHMO[6]
$0	$50 Individual, $150 Family	$50 Individual, $150 Family	$0
$1,000	$1,000	$1,000	None
Member pays	**Member pays**	**Member pays**	**Member pays**
$0[1]	$0[1]	$0[4]	$0-25
$0[1]	$0[1]	$0[4]	
$0[1]	$0[1]	$0[4]	
$0[1]	$0[1]	$0[4]	
Not covered (discount may apply)	Not covered (discount may apply)	Not covered (discount may apply)	
Not covered (discount may apply)	Not covered (discount may apply)	Not covered (discount may apply)	
Not covered (discount may apply)	Not covered (discount may apply)	Not covered (discount may apply)	
Member pays	**Member pays**	**Member pays**	**Member pays**
Not covered (discount may apply)	50%	20%	$0-250[5]
Not covered (discount may apply)	50%	20%	
Not covered (discount may apply)	50%	20%	
Not covered (discount may apply)	50%	20%	
Not covered (discount may apply)	50%	20%	
Not covered (discount may apply)	50%	20%	
Not covered (discount may apply)	50%	20%	
Member pays	**Member pays**	**Member pays**	**Member pays**
Not covered (discount may apply)	Not covered (discount may apply)	50%	$0-433
Not covered (discount may apply)	Not covered (discount may apply)	50%	
Not covered	Not covered	Not covered	Not covered
Member pays	**Member pays**	**Member pays**	**Member pays**
Not covered	Not covered	Not covered	Not covered

Adult dental benefits are current at the time of publication and are subject to change. Refer to the benefit booklet for limitations and exclusions.

1. No deductible
2. Coinsurance after deductible
3. 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.
4. Included in the Preventive Incentive. The amount paid by the plan (benefit) does not count toward the member's annual benefit maximum.
5. For Adult DHMO plan members, general anesthesia, nitrous oxide and/or IV sedation benefit is limited to covered oral surgical services for impacted teeth.
6. Members in a DHMO dental plan must utilize the KHPE DHMO network and choose an in-network Primary Dental Office (PDO) for benefits to be covered. The PDO will manage referrals for specialists.

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

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. And with the GeoBlue app, members have tools to find providers and manage care quickly anywhere in the world using their smartphones.

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

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

2019 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

For all health plans, pediatric and adult vision benefits are not subject to a deductible.

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:	$4,000/$8,000 coinsurance and copays	$6,000/$12,000 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)/Acupuncture§ (18 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 — home, office/outpatient	$50/$100	50% after ded/50% after ded
Infusion — home, office/outpatient	$20/$40	50% after ded/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/hospital-based	10% up to $35 max/10% up to $155 max	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0/50%	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10	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 $130 for frames or contact lenses; up to $180 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

Personal Choice PPO Platinum Preferred[2] $20/$40/$150		Keystone DPOS Platinum Preferred[2] $10/$20/$150		Keystone DPOS Platinum Preferred[2] $20/$40/$200	
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%
$3,500/$7,000 coinsurance and copays	$6,000/$12,000 coinsurance and ded	$4,000/$8,000 coinsurance and copays	$6,000/$12,000 coinsurance and ded	$4,500/$9,000 coinsurance and copays	$6,000/$12,000 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	$150 per day[11]	50% after ded	$200 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/$150	50% after ded/50% after ded	$50/$100	50% after ded/50% after ded	$75/$150	50% after ded/50% after ded
$40/$80	50% after ded/50% after ded	$20/$40	50% after ded/50% after ded	$40/$80	50% after ded/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	$150 per day[11]	50% after ded	$200 per day[11]	50% after ded
10% up to $45 max/10% up to $185 max	50% after ded/50% after ded	10% up to $25 max/10% up to $125 max	50% after ded/50% after ded	10% up to $45 max/10% up to $185 max	50% after ded/50% after ded
$0/50%	50% after ded/50% after ded	$0/$0	50% after ded/50% after ded	$0/$0	50% after ded/50% after ded
$0	$0	$0	$0	$0	$0
$10	70% of retail	$10	70% of retail	$10	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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 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

Platinum health plans	Keystone HMO Platinum Preferred[3] $10/$20/$150	Keystone HMO Platinum Preferred[3] $20/$40/$200
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:	$4,000/$8,000 coinsurance and copays	$4,500/$9,000 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)/Acupuncture§ (18 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)	$150 per day[11]	$200 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 — home, office/outpatient	$50/$100	$75/$150
Infusion — home, office/outpatient	$20/$40	$40/$80
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	$150 per day[11]	$200 per day[11]
Outpatient surgery		
Ambulatory surgical facility/hospital-based	10% up to $25 max/10% up to $125 max	10% up to $45 max/10% up to $185 max
Outpatient lab/pathology		
Freestanding/hospital-based	$0/$0	$0/$0
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10	$10
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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 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

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%
$5,000/$10,000 coinsurance and copays	$6,750/$13,500 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/$150	$0 after ded/$0 after ded	50% after ded/50% after ded
$60/$120	$0 after ded/$0 after ded	50% 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/10% up to $185 max	$0 after ded/$0 after ded	50% after ded/50% after ded
$0/$0	$0 after ded/$0 after ded	50% after ded/50% after ded
$0	Integrated	Integrated
$10	$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
$0	Integrated	Not covered
$0	$0 no ded	Not covered
Copay varies	$0 after ded	Not covered

Gold health plans	Personal Choice PPO Gold Preferred[2] $35/$70/$600	
Benefits per contract year[1]	**You pay in-network**	**You pay out-of-network[7]**
Deductible, individual/family	$0	$6,000/$12,000
Coinsurance	0%	50%
Out-of-pocket maximum, individual/family includes:	$7,900/$15,800 coinsurance and copays	$18,000/$36,000 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	$35	50% after ded
Specialist office visit	$70	50% after ded
Telemedicine†	$40	Not covered
Urgent care	$125	50% after ded
Spinal manipulations (20 visits per year)/Acupuncture§ (18 visits per year)	$70[9]	50% after ded[9]
Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based	$70/$100[9]	50% after ded/50% after ded[9]
Hospital/other medical services		
Inpatient hospital services (includes maternity)	$600 per day[11]	50% after ded
Inpatient professional services (includes maternity)	$0	50% after ded
Emergency room (not waived if admitted)	$450	$450 no ded
Routine Radiology — freestanding/hospital-based	$100/$130	50% after ded/50% after ded
MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based	$250/$290	50% after ded/50% after ded
Biotech/specialty injectables — home, office/outpatient	$125/$250	50% after ded/50% after ded
Infusion — home, office/outpatient	$70/$140	50% after ded/50% after ded
Durable medical equipment/prosthetics	50%	50% after ded
Mental health, serious mental illness, and substance abuse — outpatient	$70	50% after ded
Mental health, serious mental illness, and substance abuse — inpatient	$600 per day[11]	50% after ded
Outpatient surgery		
Ambulatory surgical facility/hospital-based	30% up to $300 max/30% up to $700 max	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0/50%	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10	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	Not covered
Adult routine eye exam[25]	$0	Not covered
Adult eyewear (glasses or contacts)[27]	Allowance up to $130 for frames or contact lenses; up to $180 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

Personal Choice PPO Gold Classic[2] $1,500/$15/$30/80%		Personal Choice PPO Gold Classic[2] $2,500/$40/$80/100%	
You pay in-network	**You pay out-of-network[7]**	**You pay in-network**	**You pay out-of-network[7]**
$1,500/$3,000	$7,500/$15,000	$2,500/$5,000	$7,500/$15,000
20%	50%	0%	50%
$6,000/$12,000 coinsurance, copays, and ded	$25,000/$50,000 coinsurance and ded	$4,500/$9,000 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
$15 no ded	50% after ded	$40 no ded	50% after ded
$30 no ded	50% after ded	$80 no ded	50% after ded
$40 no ded	Not covered	$40 no ded	Not covered
20% after ded	50% after ded	$125 no ded	50% after ded
$30 no ded[9]	50% after ded[9]	$80 no ded[9]	50% after ded[9]
$30 no ded/$60 no ded[9]	50% after ded/50% after ded[9]	$80 no ded/$110 no ded[9]	50% after ded/50% after ded[9]
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	20% after in-network ded	$300 no ded	$300 no ded
20% after ded/40% after ded	50% after ded/50% after ded	$70 no ded/$100 no ded	50% after ded/50% after ded
20% after ded/40% after ded	50% after ded/50% after ded	$175 no ded/$215 no ded	50% after ded/50% after ded
$100 no ded/$200 no ded	50% after ded/50% after ded	$100 no ded/$200 no ded	50% after ded/50% after ded
20% after ded/40% after ded	50% after ded/50% after ded	$0 after ded/20% after ded	50% after ded/50% after ded
50% after ded	50% after ded	50% after ded	50% after ded
$30 no ded	50% after ded	$80 no ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded/50% after ded	50% after ded/50% after ded	$0 after ded/30% after ded	50% after ded/50% after ded
$0 no ded/50% after ded	50% after ded/50% after ded	$0 no ded/50% after ded	50% after ded/50% after ded
$0	$0	$0	$0
$10	70% of retail	$10	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 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Gold health plans	Keystone DPOS Gold Classic[2] $1,500/$25/$50/90%	
Benefits per contract year[1]	**You pay in-network**	**You pay out-of-network[5]**
Deductible, individual/family	$1,500/$3,000	$7,500/$15,000
Coinsurance	10%	50%
Out-of-pocket maximum, individual/family includes:	$6,000/$12,000 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)/Acupuncture§ (18 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 — home, office/outpatient	$100 no ded/$200 no ded	50% after ded/50% after ded
Infusion — home, office/outpatient	10% after ded/30% after ded	50% after 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/hospital-based	10% after ded/40% after ded	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 no ded/$0 no ded	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10	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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Keystone DPOS Gold Preferred[2] $35/$70/$650	
You pay in-network	**You pay out-of-network[5]**
$0	$5,000/$10,000
0%	50%
$7,900/$15,800 coinsurance and copays	$15,000/$30,000 coinsurance and ded
$0	50% no ded
$0	N/A
$750	50% no ded
$35	50% after ded
$70	50% after ded
$40	Not covered
$125	50% after ded
$70[10]	50% after ded
$70/$70[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/$250	50% after ded/50% after ded
$70/$140	50% after ded/50% after ded
50%	50% after ded
$70	50% after ded
$650 per day[11]	50% after ded
30% up to $400 max/30% up to $750 max	50% after ded/50% after ded
$0/$0	50% after ded/50% after ded
$0	$0
$10	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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
$0	Not covered
$0	Not covered
Copay varies	Not covered

Gold health plans	Keystone HMO Gold Classic[2] $2,500/$40/$80/100%	Keystone HMO Gold Classic[2] $1,500/$25/$50/90%	Keystone HMO Gold Preferred[3] $35/$70/$650
Benefits per contract year[1]	**You pay in-network[6]**	**You pay in-network[6]**	**You pay in-network[6]**
Deductible, individual/family	$2,500/$5,000	$1,500/$3,000	$0
Coinsurance	0%	10%	0%
Out-of-pocket maximum, individual/family includes:	$4,500/$9,000 coinsurance, copays, and ded	$6,000/$12,000 coinsurance, copays, and ded	$7,900/$15,800 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	$40 no ded	$25 no ded	$35
Specialist office visit	$80 no ded	$50 no ded	$70
Telemedicine†	$40 no ded	$40 no ded	$40
Urgent care	$125 no ded	10% after ded	$125
Spinal manipulations (20 visits per year)/Acupuncture§ (18 visits per year)	$80 no ded	$50 no ded	$70
Physical/occupational therapy — (30 visits per year) — freestanding/hospital-based	$80 no ded/$80 no ded	$50 no ded/$50 no ded	$70/$70
Hospital/other medical services			
Inpatient hospital services (includes maternity)	$0 after ded	10% after ded	$650 per day[11]
Inpatient professional services (includes maternity)	$0 after ded	10% after ded	$0
Emergency room (not waived if admitted)	$300 no ded	10% after ded	$450
Routine Radiology — freestanding/hospital-based	$60 no ded/$60 no ded	$40 no ded/$40 no ded	$100/$100
MRI/MRA, CT/CTA/ PET scan — freestanding/hospital-based	$120 no ded/$120 no ded	$80 no ded/$80 no ded	$250/$250
Biotech/specialty injectables — home, office/outpatient	$100 no ded/$200 no ded	$100 no ded/$200 no ded	$125/$250
Infusion — home, office/outpatient	$0 after ded/20% after ded	10% after ded/30% after ded	$70/$140
Durable medical equipment/prosthetics	50% after ded	50% after ded	50%
Mental health, serious mental illness, and substance abuse — outpatient	$80 no ded	$50 no ded	$70
Mental health, serious mental illness, and substance abuse — inpatient	$0 after ded	10% after ded	$650 per day[11]
Outpatient surgery			
Ambulatory surgical facility/hospital-based	$0 after ded/30% after ded	10% after ded/40% after ded	30% up to $400 max/30% up to $750 max
Outpatient lab/pathology			
Freestanding/hospital-based	$0 no ded/$0 no ded	$0 no ded/$0 no ded	$0/$0
Prescription drugs[16, 17, 19, ‡]			
Rx deductible (individual/family)	$0	$0	$0
Retail generic[18]	$10	$10	$10
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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 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

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
$7,900/$15,800[12] coinsurance and copays	$7,900/$15,800[12] coinsurance and copays	$7,900/$15,800[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%
0%/0%	20%/20%	30%/30%
50%	50%	50%
$40	$40	$40
$350 per day[11]	$350 per day[11]	$350 per day[11]
$150/$150	$550/$550	$1,000/$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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores
$0	$0	$0
$0	$0	$0
Copay varies	Copay varies	Copay varies

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:	$6,750/$13,500 coinsurance, copays, and ded	$20,000/$40,000 coinsurance and ded	$6,750/$13,500 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)/Acupuncture§ (18 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 — home, office/outpatient	$0 after ded/$0 after ded	50% after ded/50% after ded	10% after ded/10% after ded	50% after ded/50% after ded
Infusion — home, office/outpatient	$0 after ded/$0 after ded	50% after ded/50% after ded	10% after ded/10% after ded	50% 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/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
Outpatient lab/pathology				
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
Prescription drugs[16, 17, 19, ‡]				
Rx deductible (individual/family)	Integrated	Integrated	Integrated	Integrated
Retail generic[18]	$10 after ded	50% after ded	$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Personal Choice PPO Gold HSA - 25[4] $2,600/80%		Personal Choice PPO Gold HRA - 25[2] $3,200/100%	
You pay in-network	**You pay out-of-network[7]**	**You pay in-network**	**You pay out-of-network[7]**
$2,600/$5,200	$10,000/$20,000	$3,200/$6,400	$10,000/$20,000
20%	50%	0%	50%
$6,750/$13,500 coinsurance, copays, and ded	$20,000/$40,000 coinsurance and ded	$6,750/$13,500 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
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	Not covered	$0 after ded	Not covered
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded[9]	50% after ded[9]	$0 after ded[9]	50% after ded[9]
20% after ded/20% after ded[9]	50% after ded/50% after ded[9]	$0 after ded/$0 after ded[9]	50% after ded/50% after ded[9]
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	20% after in-network ded	$0 after ded	$0 after in-network ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded	50% after ded	$0 after ded	50% after ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
20% after ded/20% after ded	50% after ded/50% after ded	$0 after ded/$0 after ded	50% after ded/50% after ded
Integrated	Integrated	Integrated	Integrated
$10 after ded	50% after ded	$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
Integrated	Not covered	Integrated	Not covered
$0 no ded	Not covered	$0 no ded	Not covered
20% after ded	Not covered	$0 after ded	Not covered

Silver health plans	Personal Choice PPO Silver Classic[2] $3,250/$30/$60/70%	
Benefits per contract year[1]	**You pay in-network**	**You pay out-of-network[7]**
Deductible, individual/family	$3,250/$6,500	$7,500/$15,000
Coinsurance	30%	50%
Out-of-pocket maximum, individual/family includes:	$7,900/$15,800 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)/Acupuncture§ (18 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 — home, office/outpatient	$100 no ded/$200 no ded	50% after ded/50% after ded
Infusion — home, office/outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Mental health, serious mental illness, 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/hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 no ded/50% after ded	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10[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 $130 for frames or contact lenses; up to $180 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

Personal Choice PPO Silver Secure[2] $4,500/$35/$70/$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]**
$4,500/$9,000	$7,500/$15,000	$4,750/$9,500	$7,500/$15,000
0%	50%	10%	50%
$7,900/$15,800 coinsurance, copays, and ded	$25,000/$50,000 coinsurance and ded	$7,900/$15,800 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
$35 no ded	50% after ded	$50 no ded	50% after ded
$70 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
$70 no ded[9]	50% after ded[9]	$100 no ded[9]	50% after ded[9]
$70 no ded/$100 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 per 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/$200 no ded	50% after ded/50% after ded	$100 no ded/$200 no ded	50% after ded/50% after ded
$0 after ded/20% after ded	50% after ded/50% after ded	10% after ded/30% after ded	50% after ded/50% after ded
50% after ded	50% after ded	50% after ded	50% after ded
$70 no ded	50% after ded	$100 no ded	50% after ded
Subject to ded and $600 per day[11]	50% after ded	10% after ded	50% after ded
40% after ded up to $600 max/40% after ded up to $600 max	50% after ded/50% after ded	10% after ded/30% after ded	50% after ded/50% after ded
$0 no ded/50% after ded	50% after ded/50% after ded	$0 no ded/50% after ded	50% after ded/50% after ded
$0	$0	$0	$0
$10[20]	70% of retail	$10[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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Silver health plans	Keystone DPOS Silver Classic[2] $4,250/$25/$50/70%	
Benefits per contract year[1]	**You pay in-network**	**You pay out-of-network[5]**
Deductible, individual/family	$4,250/$8,500	$7,500/$15,000
Coinsurance	30%	50%
Out-of-pocket maximum, individual/family includes:	$7,900/$15,800 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)/Acupuncture§ (18 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	$120 no ded/$120 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 — home, office/outpatient	$100 no ded/$200 no ded	50% after ded/50% after ded
Infusion — home, office/outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Mental health, serious mental illness, 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/hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 no ded/$0 no ded	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18]	$10[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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

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%
$7,900/$15,800 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
$120 no ded/$120 no ded[10]	50% after ded/50% after ded
$250 no ded/$250 no ded	50% after ded/50% after ded
$100 no ded/$100 no 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
$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/$0 no ded	50% after ded/50% after ded
$0	$0
$10[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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
$0	Not covered
$0	Not covered
Copay varies	Not covered

Silver health plans	Keystone HMO Silver Classic[2] $4,250/$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	$4,250/$8,500	$3,250/$6,500
Coinsurance	30%	50%
Out-of-pocket maximum, individual/family includes:	$7,900/$15,800 coinsurance, copays, and ded	$7,900/$15,800 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)/Acupuncture§ (18 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	$120 no ded/$120 no ded	$120 no ded/$120 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 — home, office/outpatient	$100 no ded/$200 no ded	$100 no ded/$100 no ded
Infusion — home, office/outpatient	30% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Mental health, serious mental illness, 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/hospital-based	30% after ded/50% after ded	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 no ded/$0 no ded	$0 no ded/$0 no ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	$0	$0
Retail generic[18,20]	$10	$10
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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 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

Keystone HMO Silver Classic[2] $4,500/$40/$80/100%	Keystone HMO Silver Secure[2] $5,000/$40/$80/$600
You pay in-network[6]	**You pay in-network[6]**
$4,500/$9,000	$5,000/$10,000
0%	0%
$7,900/$15,800 coinsurance, copays, and ded	$7,900/$15,800 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 per day[11]
$0 after ded	$0 after ded
$300 after ded	$300 after ded
$120 no ded/$120 no ded	$120 no ded/$120 no ded
$250 no ded/$250 no ded	$250 no ded/$250 no ded
$100 no ded/$200 no ded	$100 no ded/$200 no ded
$0 after ded/20% after ded	$0 after ded/20% after ded
50% after ded	50% after ded
$80 no ded	$80 no ded
$0 after ded	Subject to ded and $600 per day[11]
$0 after ded/30% after ded	30% after ded up to $600 max/30% after ded up to $600 max
$0 no ded/$0 no ded	$0 no ded/$0 no ded
$0	$0
$10	$10
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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores
$0	$0
$0	$0
Copay varies	Copay varies

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)/Acupuncture§ (18 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 — home, office/outpatient
Infusion — home, office/outpatient
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]

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	$6,000/$12,000[15]	$6,000/$12,000[15]
0%; unless otherwise noted	5%; unless otherwise noted	10%; unless otherwise noted
$7,900/$15,800[12] coinsurance and copays	$7,900/$15,800[12] coinsurance, copays, and ded	$7,900/$15,800[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]	$60 no ded[13]	$70 no ded[13]
$80	$120 no ded	$140 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%	50% no ded/50% no ded	50% no ded/50% no ded
0%/0%	5% after ded/5% after ded	10% after ded/10% after 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 /$250	Subject to ded and $750 copay/Subject to ded and $750 copay	Subject to ded and $1,250 copay/Subject to ded and $1,250 copay
$0/$0	$0 no ded/$0 no ded	$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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores
$0	$0	$0
$0	$0	$0
Copay varies	Copay varies	Copay varies

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:	$6,750/$13,500 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)/Acupuncture§ (18 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 — home, office/outpatient	$0 after ded/$0 after ded	50% after ded/50% after ded
Infusion — home, office/outpatient	$0 after ded/$0 after ded	50% 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/hospital-based	$0 after ded/$0 after ded	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 after ded/$0 after ded	50% after ded/50% after ded
Prescription drugs[16, 17, 19, ‡]		
Rx deductible (individual/family)	Integrated	Integrated
Retail generic[18]	$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Personal Choice PPO Silver HSA - O[4] $2,700/90%	
You pay in-network	**You pay out-of-network[7]**
$2,700/$5,400	$10,000/$20,000
10%	50%
$6,750/$13,500 coinsurance, copays, and ded	$20,000/$40,000 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/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/10% after ded	50% after ded/50% after ded
10% after ded/10% after ded	50% after ded/50% after ded
Integrated	Integrated
$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
Integrated	Not covered
$0 no ded	Not covered
10% after ded	Not covered

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)/Acupuncture§ (18 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 — home, office/outpatient
Infusion — home, office/outpatient
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]

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%
$6,750/$13,500 coinsurance, copays, and ded	$20,000/$40,000 coinsurance and ded	$6,750/$13,500 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/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/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
Integrated	Integrated	Integrated
$10 after ded[20]	50% after ded	$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores
Integrated	Not covered	Integrated
$0 no ded	Not covered	$0 no ded
30% after ded	Not covered	20% after ded

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:	$7,900/$15,800 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)/Acupuncture§ (18 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 per 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 — home, office/outpatient	$100 no ded/$100 no ded	50% after ded/50% after ded
Infusion — home, office/outpatient	50% after ded/50% after ded	50% after ded/50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Mental health, serious mental illness, and substance abuse — outpatient	$100 no ded	50% after ded
Mental health, serious mental illness, and substance abuse — inpatient	Subject to ded and $700 per day[11]	50% after ded
Outpatient surgery		
Ambulatory surgical facility/hospital-based	30% after ded up to $750 max/30% after ded up to $750 max	50% after ded/50% after ded
Outpatient lab/pathology		
Freestanding/hospital-based	$0 no ded/$0 no ded	50% after 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	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

Keystone HMO Bronze Essential[2] $6,850/$50/$100/$700	Personal Choice PPO Bronze HSA - O[4] $6,750/100%	
You pay in-network[6]	**You pay in-network**	**You pay out-of-network[7]**
$6,850/$13,700	$6,750/$13,500	$10,000/$20,000
50%	0%	50%
$7,900/$15,800 coinsurance, copays, and ded	$6,750/$13,500 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 per 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/$100 no ded	$0 after ded/$0 after ded	50% after ded/50% after ded
50% after ded/50% after ded	$0 after ded/$0 after ded	50% 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 per day[11]	$0 after ded	50% after ded
30% after ded up to $750 max/30% after ded up to $750 max	$0 after ded/$0 after ded	50% after ded/50% after ded
$0 no ded/$0 no ded	$0 after ded/$0 after ded	50% 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Allowance up to $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
$0	Integrated	Not covered
$0	$0 no ded	Not covered
Copay varies	0% after ded	Not covered

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)/Acupuncture§ (18 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 — home, office/outpatient
Infusion — home, office/outpatient
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]

Personal Choice PPO Bronze HSA - O[4]
$5,200/50%

You pay in-network	You pay out-of-network[7]
$5,200/$10,400	$10,000/$20,000
50%	50%
$6,750/$13,500 coinsurance, copays, and ded	$20,000/$40,000 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	50% after ded/50% after ded
50% after ded/50% after ded	50% after ded/50% after ded
Integrated	Integrated
$10 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 $130 for frames or contact lenses; up to $180 frame allowance at Visionworks stores	Not covered
Integrated	Not covered
$0 no ded	Not covered
50% after ded	Not covered

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 hypnotherapy
- 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. Diagnostic colonoscopies are subject to the cost-sharing provision of the member's outpatient surgery benefit. 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. Vision benefits are not subject to a deductible.

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. Allowance up to $130 for frames or contact lenses at Davis Vision participating providers; up to $180 frame allowance at Visionworks stores. Medical plan deductibles do not apply to vision benefits.

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.

§ Acupuncture is covered for limited conditions. Please reference the medical policy for details on covered conditions.

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, the employer must contribute a minimum of 25 percent of the lowest-cost option's gross monthly premium.

Off-anniversary benefit change

- Upgrades and downgrades will only be allowed on anniversary.

High-deductible health plan funding limitation

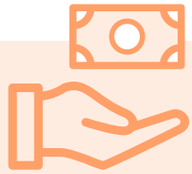
- Per Affordable Care Act regulations, employers should not fund more or less than the federally mandated standards for funding employee deductibles.
- The high-deductible plan design selected will specify the funding requirement. Please refer to each plan design for specific funding requirements.

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 $3,200/100%
Contribution requirement	50% of deductible	25% of deductible
Plan deductible (Individual/family)	$1,600/$3,200	$3,200/$6,400
Employer contribution amount	$800/$1,600	$800/$1,600

The Tuition Rewards program is provided by College Tuition Benefit, an independent company. This is a value-added program and not a benefit under an Independence health plan and is, therefore, subject to change without notice. Neither College Tuition Benefit nor Sage Scholars, Inc. provide Blue Cross products or services.

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. Tuition Rewards® are NOT awarded in cash.

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.

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.

Independence

Blue Solutions®

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