



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ibx.com/IndBooklet or by calling 1-800-ASK-BLUE (TTY:711).

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	For Tier 1 Preferred: \$0 per person / \$0 per family, Tier 2 Enhanced: \$5,500 per person / \$11,000 per family, Tier 3 Standard: \$5,500 per person / \$11,000 per family. Deductible may not apply to all services.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes, there is a \$50 deductible for pediatric dental services.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For participating providers \$7,150 person / \$14,300 family.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	Yes. Electronic referral required.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have the plan's permission before you see the <u>specialist</u> .
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed in the Excluded Services & Other Covered Services section. See your policy or plan document for additional information about <u>excluded services</u> .

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- Copayments are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance is *your* share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan's allowed amount for an overnight hospital stay is \$1,000, your coinsurance payment of 20% would be \$200. This may change if you haven't met your deductible.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the allowed amount is \$1,000, you may have to pay the \$500 difference. (This is called balance billing.)
- This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$30 Copayment (copay)	\$40 copay, no Deductible (ded)	\$50 copay, no ded	-----none-----
	Specialist visit	\$60 copay	\$80 copay, no ded	\$100 copay, no ded	PCP referral required.
	Other practitioner office visit	\$50 copay	\$50 copay, no ded	\$50 copay, no ded	PCP referral required for spinal manipulation. Visit limits may apply. See benefit booklet.
	Preventive care / screening / immunization	No Charge	No Charge no ded	No Charge no ded	Age and frequency schedules may apply. For colorectal cancer screening, your cost share may vary depending on where you receive service.
If you have a test	Diagnostic test (x-ray, blood work)	\$60 copay(X-Ray)/ No Charge(Blood Work)	\$60 copay, no ded(X-Ray)/ No Charge no ded(Blood Work)	\$60 copay, no ded(X-Ray)/ No Charge no ded(Blood Work)	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	\$250 copay	\$250 copay, no ded	\$250 copay, no ded	Precertification required for certain services. See benefit booklet.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.ibx.com/ffm/formulary5s	Generic drugs	\$15 copay (Retail)/\$15 copay (1-30 days supply)(Mail Order); \$30 copay (31-90 days supply)(Mail Order)	\$15 copay (1-30 days supply/Retail & Mail); \$30 copay (31-90 days supply/Mail)	\$15 copay (Retail)/\$15 copay (1-30 days supply)(Mail Order); \$30 copay (31-90 days supply)(Mail Order)	Preferred Generics available at a reduced cost. Prior authorization and/or dispensing limits may apply. This plan has a Preferred Pharmacy Network which excludes Walgreens and Rite-Aid. See benefit booklet.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	
	Preferred Brand	50% Coinsurance (co-ins) with a Maximum (max) member payment of \$400/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$800/prescription(31-90/Mail)	50% co-ins with a max member payment of \$400/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$800/prescription(31-90/Mail)	50% co-ins with a max member payment of \$400/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$800/prescription(31-90/Mail)	Prior authorization required on some drugs, age, gender and quantity limits for some drugs; day's supply limits on retail & mail order. Mandatory Generic. See benefits booklet.
	Non-preferred drugs	50% co-ins with a max member payment of \$500/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$1000/prescription(31-90/Mail)	50% co-ins with a max member payment of \$500/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$1000/prescription(31-90/Mail)	50% co-ins with a max member payment of \$500/prescription(1-30 days supply/Retail & Mail); 50% co-ins with a max member payment of \$1000/prescription(31-90/Mail)	Prior authorization required on some drugs, age, gender and quantity limits for some drugs; day's supply limits on retail & mail order. Mandatory Generic. See benefits booklet.
	Specialty drugs	50% co-ins with a max member payment of \$700/ prescription	50% co-ins with a max member payment of \$700/ prescription	50% co-ins with a max member payment of \$700/ prescription	This applies to self-administered specialty drugs covered under the prescription drug plan. Limited to a maximum 30 days supply. Prior authorization and/or additional dispensing limits may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copay	Subject to ded and \$750 copay	Subject to ded and \$1,250 copay	Precertification may be required. See benefit booklet.
	Physician/surgeon fees	No Charge	5%, after ded	10%, after ded	Precertification may be required. See benefit booklet.
If you need immediate medical attention	Emergency room services	\$550 copay	\$550 copay, no ded	\$550 copay, no ded	-----none-----
	Emergency medical transportation	\$200 copay	\$200 copay, no ded	\$200 copay, no ded	-----none-----
	Urgent care	\$100 copay	\$100 copay, no ded	\$100 copay, no ded	Your costs for urgent care are based on care received at a designated urgent care center or facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$500/ day; max of 5 Copayments (copays)/ Admission (adm)	Subject to ded and \$900/ day; max of 5 copays/ adm	Subject to ded and \$1,300/ day; max of 5 copays/ adm	Precertification required.

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	
	Physician/surgeon fee	No Charge	5%, after ded	10%, after ded	Precertification required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60 copay	\$60 copay, no ded	\$60 copay, no ded	-----none-----
	Mental/Behavioral health inpatient services	\$500/ day; max of 5 copays/ adm	\$500/ day, no ded; max of 5 copays/ adm	\$500/ day, no ded; max of 5 copays/ adm	Precertification required.
	Substance abuse disorder outpatient services	\$60 copay	\$60 copay, no ded	\$60 copay, no ded	Precertification required.
	Substance abuse disorder inpatient services	\$500/ day; max of 5 copays/ adm	\$500/ day, no ded; max of 5 copays/ adm	\$500/ day, no ded; max of 5 copays/ adm	Precertification required.
If you are pregnant	Prenatal and postnatal care	\$60 copay	\$80 copay, no ded	\$100 copay, no ded	Your cost is for first OB visit only.
	Delivery and all inpatient services	\$500/ day; max of 5 copays/ adm	Subject to ded and \$900/ day; max of 5 copays/ adm	Subject to ded and \$1,300/ day; max of 5 copays/ adm	Pre-notification requested.
If you need help recovering or have other special health needs	Home health care	No Charge	5%, after ded	10%, after ded	Precertification required. Limits may apply. See benefit booklet.
	Rehabilitation services	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	PCP referral required for Physical/Occupational therapies. Visit limits may apply. See benefit booklet.
	Habilitation services	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	\$60 Copay, no ded(PT/OT); \$70 Copay, no ded(Speech)	PCP referral required for Physical/Occupational therapies. Visit limits may apply. See benefit booklet.
	Skilled nursing care	\$250/ day; max of 5 copays/ adm	\$250/ day, no ded; max of 5 copays/ adm	\$250/ day, no ded; max of 5 copays/ adm	Precertification required. Limits may apply. See benefit booklet.
	Durable medical equipment	50%	50%, no ded	50%, no ded	Precertification required for selected items. See benefit booklet.
	Hospice service	No Charge	No Charge no ded	No Charge no ded	-----none-----
If your child needs dental or eye care	Eye exam	No charge	No charge	No charge	Once every calendar year
	Glasses	No charge	No charge	No charge	1 pair of glasses (lenses/ frames) or contacts per calendar year
	Dental check-up	No charge, no deductible	No charge, no deductible	No charge, no deductible	1 per six months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Abortions, except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed
- Acupuncture
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S. (For details, see www.ibx.com)
- Routine foot care
- Bariatric surgery
- Hearing aids
- Private-duty nursing
- Weight loss programs
- Cosmetic surgery
- Long-term care
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Infertility treatment (See Benefit Booklet/Member handbook for limitations)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium.

There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-671-5276 (TTY:711).

You may also contact your state insurance department. Pennsylvania Insurance Department - Bureau of Consumer Services

1209 Strawberry Square - Harrisburg, PA. 17120 - Phone: 1-877-881-6388 - Fax: 1-717-787-8585

Your Grievance and Appeals Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-866-681-7373 (TTY:711). As an alternative, the Pennsylvania Department of Insurance can also provide assistance. Please contact them at 1-877-881-6388.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage". This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

-----*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*-----

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan Pays \$6,190
- Patient Pays \$1,350

Sample Care Costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient Pays

Deductibles	\$0
Copays	\$1,200
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$1,350

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan Pays \$3,710
- Patient Pays \$1,690

Sample Care Costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient Pays

Deductibles	\$0
Copays	\$600
Coinsurance	\$1,010
Limits or exclusions	\$80
Total	\$1,690

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✔ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✔ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

Appeal

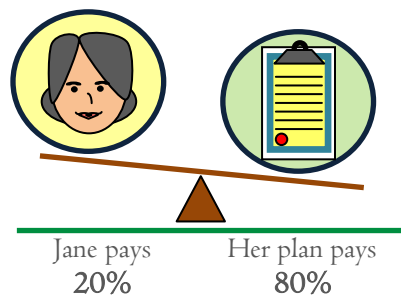
A request for your health insurer or **plan** to review a decision or a **grievance** again.

Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

Co-insurance

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



(See page 4 for a detailed example.)

Complications of Pregnancy

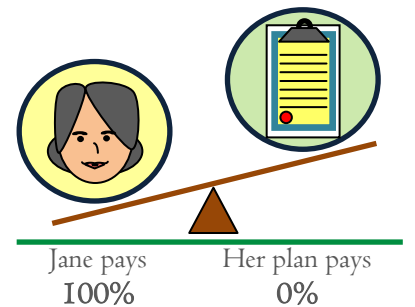
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment

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

Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

Emergency Room Care

Emergency services you get in an emergency room.

Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

Grievance

A complaint that you communicate to your health insurer or **plan**.

Habilitation Services

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

Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

Home Health Care

Health care services a person receives at home.

Hospice Services

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

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

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

In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

In-network Co-payment

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

Medically Necessary

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

Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or plan, or if your health insurance or plan has a "tiered" **network** and you must pay extra to see some providers.

Out-of-network Co-insurance

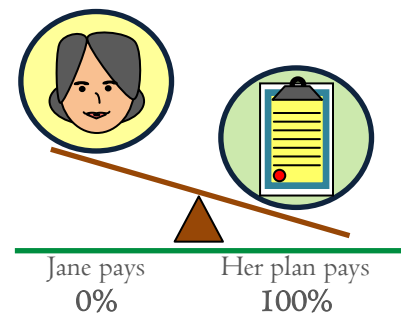
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

Out-of-network Co-payment

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

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.



(See page 4 for a detailed example.)

Physician Services

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

Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization

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

Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium

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

Prescription Drug Coverage

Health insurance or **plan** that helps pay for **prescription drugs** and medications.

Prescription Drugs

Drugs and medications that by law require a prescription.

Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery

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

Rehabilitation Services

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

Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)

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

Urgent Care

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

How You and Your Insurer Share Costs - Example

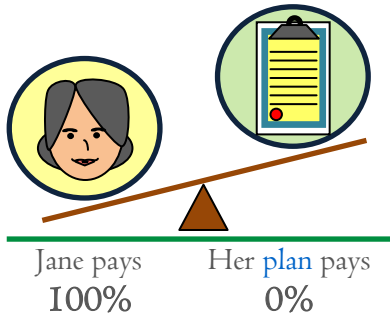
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

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

January 1st
Beginning of Coverage
Period

December 31st
End of Coverage Period



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

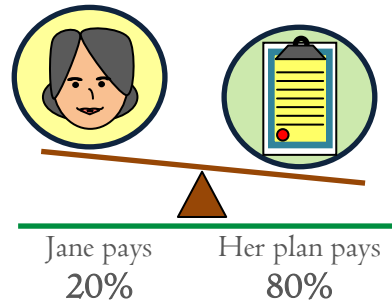
Her plan doesn't pay any of the costs.

Office visit costs: \$125

Jane pays: \$125

Her plan pays: \$0

more costs



Jane reaches her \$1,500 deductible, co-insurance begins

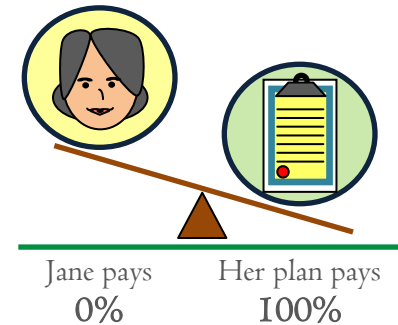
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.

Office visit costs: \$75

Jane pays: 20% of \$75 = \$15

Her plan pays: 80% of \$75 = \$60

more costs



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

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

Office visit costs: \$200

Jane pays: \$0

Her plan pays: \$200

Language Access Services

If you, or someone you're helping, has questions about Independence Blue Cross, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-275-2583 TTY 711.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Independence Blue Cross, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-275-2583 TTY 711.

如對 Independence Blue Cross 有任何問題，請您或您所幫助的人聯系我們提供的免費多語言信息服務。翻譯服務請撥打 1-800-275-2583。

Nếu quý vị hoặc người mà quý vị đang trợ giúp có câu hỏi về Independence Blue Cross, quý vị có quyền nhận được trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để yêu cầu thông dịch viên, hãy gọi số 1-800-275-2583.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу программы Independence Blue Cross, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-275-2583.

Wann du hoscht en Froog, odder ebber, wu du helpscht, hot en Froog baut Independence Blue Cross, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-800-275-2583 uffrufe.

Independence Blue Cross 와 관련하여 궁금한 사항이 있으신 경우, 귀하 또는 귀하의 지원을 받는 사람은 관련 정보 및 지원을 해당 언어로 무료로 받으실 수 있습니다. 통역사와 상담하시려면 1-800-275-2583 로 전화해 주십시오.

Se tu o qualcuno che stai aiutando avete domande su Independence Blue Cross, hai il diritto di ottenere gratuitamente aiuto e informazioni nella tua lingua. Per parlare con un interprete, puoi chiamare il numero 1-800-275-2583.

إذا كان لديك أو لدى شخص تساعد أسئلة بخصوص Independence Blue Cross، فلديك الحق في الحصول على المعلومات الضرورية بلغتك دون أي تكلفة. للتحدث مع مترجم اتصل بـ 1-800-275-2583.

Si vous, ou quelqu'un que vous aidez, a des questions à propos d'Independence Blue Cross, vous avez le droit d'obtenir gratuitement de l'aide et l'information dans votre langue. Pour parler à un interprète, appelez 1-800-275-2583.

Wenn Sie selbst oder eine Person, der Sie helfen, Fragen über Independence Blue Cross haben, so haben Sie das Recht, kostenlos Hilfe und Informationen in Ihrer Sprache anzufordern. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-800-275-2583 an.

જો તમને અથવા તમે કોઈને મદદ કરી રહ્યા તેમાંથી કોઈને Independence Blue Cross વિશે પ્રશ્નો હોય, તો તમને મદદ અને માહિતી તમારી ભાષામાં કોઈપણ ખર્ચ વિના મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, આ 1-800-275-2583 પર કોલ કરો

Jeśli Ty lub osoba, której pomagasz macie pytania odnośnie do programu Independence Blue Cross, mogą Państwo uzyskać bezpłatną informację i pomoc w Waszym języku. Aby porozmawiać z tłumaczem, proszę zadzwonić pod numer 1-800-275-2583.

Si ou menm, oswa yon moun w ap ede, gen kesyon konsènan Independence Blue Cross, ou gen dwa pou resevwa èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele 1-800-275-2583.

បើអ្នក ឬក៏នរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Independence Blue Cross អ្នកមានសិទ្ធិក្នុងការទទួលជំនួយនិង ព័ត៌មានជាភាសារបស់អ្នក ដោយឥតគិតថ្លៃ។ ដើម្បីជជែកជាមួយអ្នកបកប្រែ សូមហៅទូរសព្ទទៅលេខ 1-800-275-2583។

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Independence Blue Cross, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-800-275-2583.

Dii kwe'é atah nilinigií Independence Blue Cross haada yit'éego bina idilkidgo ei doodago háida biká anilyeedigií t'áadoo le'é yina'idilkidgo bee ná ahóót'i'díi t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílinigóó. Ata' halne'ígíi' kojí' bich'í' hodíílnih 1-800-275-2583.

Kung ikaw, o ang taong iyong tinutulungan, ay may mga katanungan tungkol sa Independence Blue Cross, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang interpreter, tumawag sa 1-800-275-2583.

ご本人やお客様の周りの人が、Independence Blue Cross についてご質問などがある場合、無料でご希望の言語でのサポートや情報を入手することができます。インタプリタをご利用の方は、1-800-275-2583 までお電話ください。

اگر شما یا شخصی که به وی کمک می کنید، در رابطه با Independence Blue Cross سوالی دارید، این حق برای شما محفوظ است که بدون نیاز به پرداخت هر نوع هزینه، اطلاعات مربوطه را به زبان خود دریافت نمایید. جهت گفتگو با یک مترجم، با شماره 1-800-275-2583 تماس حاصل فرمایید.

Nondiscrimination Notice & Notice of Availability of Auxiliary Aids & Services

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

Independence Blue Cross:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that Independence Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You have five ways to file a grievance:

- In person or by mail :
Independence Blue Cross
ATTN: Civil Rights Coordinator
1901 Market Street
Philadelphia, PA 19103
- By phone: 888-377-3933 (TTY 711)
- By fax: 215-761-0245
- By email: civilrightscordinator@ibx.com

If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

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