Silver health plans	OFF Keystone HMO Silver Proactive Value[2]		
Benefits per calendar year[1]	**You pay in-network[3] Tier 1 – Preferred**	**You pay in-network[3] Tier 2 – Enhanced**	**You pay in-network[3] Tier 3 – Standard**
Ded, individual/family[10]	$1,500/$3,000	$6,000/$12,000	$6,000/$12,000
Coinsurance	0% unless otherwise noted	5% unless otherwise noted	10% unless otherwise noted
Out-of-pocket maximum, individual/family includes:[11]	$8,150/$16,300 copay, ded, and coinsurance	$8,150/$16,300 copay, ded, and coinsurance	$8,150/$16,300 copay, ded, and coinsurance
Preventive services[5]			
Preventive care for adults and children	0% no ded	0% no ded	0% no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	0% no ded	0% no ded	0% no ded
Preventive colonoscopy for colorectal cancer screening — Hospital-based	$750 no ded	$750 no ded	$750 no ded
Physician services			
Primary care office visit/retail clinic[13]	$40 no ded	$60 no ded	$70 no ded
Specialist office visit	$80 no ded	$120 no ded	$140 no ded
Telemedicine[28]	$20 no ded	$20 no ded	$20 no ded
Urgent care	$100 no ded	$100 no ded	$100 no ded
Spinal manipulations (20 visits per year)[6]	$50 no ded	$50 no ded	$50 no ded
Physical/occupational therapy (30 visits per year) Freestanding/Hospital-based[6]	$80 no ded/$80 no ded	$80 no ded/$80 no ded	$80 no ded/$80 no ded
Hospital/other medical services			
Inpatient hospital services (includes maternity)	Subject to ded and $600 per day[7]	Subject to ded and $900 per day[7]	Subject to ded and $1,300 per day[7]
Inpatient professional services (includes maternity)	0% after ded	5% after ded	10% after ded
Emergency room (not waived if admitted)[12]	$550 no ded	$550 no ded	$550 no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	$120 no ded/$120 no ded	$120 no ded/$120 no ded	$120 no ded/$120 no ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	$250 no ded/$250 no ded	$250 no ded/$250 no ded	$250 no ded/$250 no ded
Biotech/specialty injectables — Home, office/outpatient	50% no ded/50% no ded	50% no ded/50% no ded	50% no ded/50% no ded
Infusion — Home, office/outpatient	0% after ded/0% after ded	5% after ded/5% after ded	10% after ded/10% after ded
Durable medical equipment/prosthetics	50% no ded	50% no ded	50% no ded
Mental health, serious mental illness & substance abuse — outpatient	$80 no ded	$80 no ded	$80 no ded
Mental health, serious mental illness & substance abuse — inpatient	Subject to ded and $600 per day[7]	Subject to ded and $600 per day[7]	Subject to ded and $600 per day[7]
Outpatient surgery			
Ambulatory surgical facility	Subject to ded and $250 copay	Subject to ded and $750 copay	Subject to ded and $1,250 copay
Hospital-based	Subject to ded and $250 copay	Subject to ded and $750 copay	Subject to ded and $1,250 copay
Outpatient lab/pathology			
Freestanding	0% no ded	0% no ded	0% no ded
Hospital-based	0% no ded	0% no ded	0% no ded
Prescription drugs[14,15,17,†]			
Rx ded (individual/family)[‡]	$250/$500	$250/$500	$250/$500
Retail generic[16,19]	$20 no ded	$20 no ded	$20 no ded
Retail preferred brand[16,18]	50% after ded up to $400	50% after ded up to $400	50% after ded up to $400
Retail non-preferred drug[16,18]	50% after ded up to $500	50% after ded up to $500	50% after ded up to $500
Specialty[18]	50% after ded up to $1,000	50% after ded up to $1,000	50% after ded up to $1,000
Additional benefits			
Vision[20,21]			
Pediatric exam & pediatric eyewear[22,23]	$0 no ded	$0 no ded	$0 no ded
Dental[24,25]			
Pediatric dental ded (per individual)	$50	$50	$50
Pediatric exams and cleanings[26]	$0 no ded	$0 no ded	$0 no ded
Pediatric basic, major, and orthodontia services[27]	50% after ded	50% after ded	50% after ded

OFF These plans are not offered on HealthCare.gov and must be purchased through Independence directly.

ded = Deductible

Health plan footnotes

Medical

* Retail clinic services are subject to 0 percent coinsurance after deductible.

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

2 Embedded Deductible: Family deductible and out-of-pocket maximum apply when more than one person is covered under a plan. A covered family member only needs to satisfy his or her individual deductible before receiving plan benefits. Once the family deductible is met, then all covered family members will receive plan benefits. A covered family member only needs to satisfy his or her out-of-pocket maximum before that individual's benefits are covered in full. Once the family out-of-pocket is met, then all covered family members' benefits will be covered in full.

3 There are no out-of-network services available except for emergency services.

4 Out-of-Network providers may bill you for differences between the Plan allowance, which is the amount paid by Independence, 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.

5 Age and frequency schedules may apply. In order to get a preventive colonoscopy without having to pay any out-of-pocket costs, you must choose Preventive Plus providers and GI professionals (gastroenterologists or colon and rectal surgeons) that are not hospital-based to perform the preventive colonoscopy. To find a Preventive Plus provider, visit ibx.com/findadoctor.

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

7 Amount shown reflects the copay per day. There is a maximum of five copays per admission.

8 For this plan, inpatient maternity hospital services are subject to 30 percent coinsurance after deductible.

9 For PPO Bronze, inpatient maternity hospital services are subject to 50 percent coinsurance after deductible.

Keystone HMO Proactive

10 For Keystone HMO Silver Proactive the deductible is combined for Tiers 2 and 3.

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

12 For Keystone HMO Proactive plans, if you are 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. Out-of-network providers for emergency services will be covered at the Tier 3 level of benefits.

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

Prescription drugs

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

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

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

17 This plan utilizes the FutureScripts Preferred Pharmacy Network — a subset of the national retail pharmacy network. It includes over 59,000 pharmacies, including most major chains and local pharmacies except Rite Aid. With plans that use the Preferred Pharmacy network, filling a prescription at a non-participating pharmacy is considered out-of-network, and members must pay the total cost upfront. 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.

18 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and the member will be responsible for the cost-sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If the member purchases a brand drug, the member will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate cost-sharing for a brand drug.

19 Certain designated generic drugs are available at participating retail and mail order pharmacies for a reduced member cost-sharing ($4 retail / $8 mail order), after any applicable deductible.

† For all plans, member pays cost-sharing per each fill unless out -of-pocket max has been met.

‡ 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.

Additional benefits

20 Independence vision plans are administered by Davis Vision, an independent company.

21 Pediatric vision benefits expire at the end of the month in which the child turns 19.

22 One eye exam per calendar year period.

23 Pediatric spectacle lenses covered at no extra cost include: single vision, lined bifocal, lined trifocal, or lenticular lenses. For frames to be covered in full, choose from Davis Vision's Pediatric Frame Selection (available at most independent participating providers). Davis Vision Contact Lenses Collection is covered in full at participating independent providers.

24 Independence dental plans are administered by United Concordia Companies, Inc., an independent company.

25 Pediatric dental benefits are covered until the end of the calendar year in which the child turns 19.

26 One exam and one cleaning every six months per calendar year.

27 Only medically necessary orthodontia is covered.

28 Independence telemedicine benefits are administered by MDLIVE, an independent company.

ded = Deductible