## Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>See the chart starting on page 2 for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services, but see the chart</td>
</tr>
<tr>
<td></td>
<td></td>
<td>starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers $1,500 person / $3,000 family.</td>
<td>The out-of-pocket limit 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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.ibx.com/find_a_provider">www.ibx.com/find_a_provider</a> or call 1-800-ASK-BLUE for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, 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 provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>Yes. Electronic referral required.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed in the Excluded Services &amp; Other Covered Services section. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

### Questions:
Call 1-800-ASK-BLUE or visit us at www.ibx.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.ibx.com or call 1-800-ASK-BLUE to request a copy.
- **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a Referred Provider</td>
<td>an Out Of Network Provider</td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$25 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$35 copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care / screening / immunization</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/ PET scans, MRIs)</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$20 Copayment (Retail)/$20 Copayment (1-30 days supply)(Mail Order); $40 Copayment (31-90 days supply)(Mail Order)</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40 Copayment (Retail)/$40 Copayment (1-30 days supply)(Mail Order); $80 Copayment (31-90 days supply)(Mail Order)</td>
<td>70%</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at [http://www.ibx.com/preapproval](http://www.ibx.com/preapproval)
<table>
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<th>Your Cost If You Use</th>
<th>Limitations &amp; Exceptions</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>a Referred Provider</td>
<td>an Out Of Network Provider</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 Copayment (Retail)/ $60 Copayment (1-30 days supply)(Mail Order); $120 Copayment (31-90 days supply)(Mail Order)</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>Covered with a $150 copayment</td>
<td>Covered with a $150 copayment</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Covered No Charge when medically necessary</td>
<td>Covered No Charge when medically necessary</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$105 Copayment</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$100 Copayment/ admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Substance abuse disorder outpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>----------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a Referred Provider</td>
<td>an Out Of Network Provider</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Substance abuse disorder inpatient services</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Prenatal and postnatal care</td>
<td>Covered with a $35 copayment for the first visit. Subsequent visits to your OB/GYN covered No Charge. Inpatient care covered with a $100 copayment per admission</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>Covered No Charge up to 180 days per calendar year</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>All purchases and rentals (including repairs and replacements) are covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Covered No Charge. Up to 60 consecutive days per condition covered, after significant improvement</td>
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<td>Skilled nursing care</td>
<td>Covered No Charge up to 180 days per calendar year</td>
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<td></td>
<td>Durable medical equipment</td>
<td>All purchases and rentals (including repairs and replacements) are covered No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>No Charge</td>
<td>Not Covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eye exam</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
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.)

- Acupuncture
- Hearing aids
- Non-emergency care when traveling outside the U.S. (For details, see [www.ibx.com](http://www.ibx.com))
- Cosmetic surgery
- Infertility treatment (See Benefit Booklet/ Member handbook for limitations)
- Routine foot care
- Dental care (Adult)
- Long-term care
- Weight loss programs

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.)

- Bariatric surgery
- Chiropractic care
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-888-671-5276. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

Your Grievance and Appeals Rights:

Your health plan is subject to Employee Retirement Income Security Act (ERISA) requirements. If you are dissatisfied with a denial of coverage for claims under your plan, you may contact IBC at 1-800-ASK-BLUE. You may also contact the U.S. Dept. of Labor Employee Benefits Security Administration at 1-866-444-3272. 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.

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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.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan Pays</strong> $7,370</td>
</tr>
<tr>
<td><strong>Patient Pays</strong> $170</td>
</tr>
</tbody>
</table>

**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: $20
- Coinsurance: $0
- Limits or exclusions: $150

**Total**: $170

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan Pays</strong> $3,570</td>
</tr>
<tr>
<td><strong>Patient Pays</strong> $1,830</td>
</tr>
</tbody>
</table>

**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: $1,750
- Coinsurance: $0
- Limits or exclusions: $80

**Total**: $1,830
**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.

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**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.

**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.

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**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.

**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.

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

Jane pays 100%  Her plan pays 0%

Jane hasn’t reached her $1,500 deductible yet
Her plan doesn’t pay any of the costs.
Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, 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

December 31st
End of Coverage Period

Jane pays 0%  Her plan pays 100%

Jane reaches her $5,000 out-of-pocket limit
Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.
Office visit costs: $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.

如对Independence Blue Cross有任何问题，请您或您所帮助的人联系我们提供的免费多语言信息服务。翻译服务请拨打 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.


Independence Blue Cross와 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.

اذكروا الحق في الحصول على المعلومات الضرورية بلغتك. Independence Blue Cross إذا كان لديك أو لدى شخص تساعده أسئلة بخصوص 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.

만약 어떤 사람을 돕고 있다거나 Independenence Blue Cross에 대해 물어보는 않을 경우, 지원 차원의 도움을 받을 수 있다. 언어로 무료로 받으실 수 있습니다. 통역사와 상담하려면 1-800-275-2583로 전화해 주십시오.

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 entèpré, rele 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.

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.
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:** civilrightscoordinator@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](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).