Independence Chester County Intermediate Unit: PPO

Coverage for: Individual/Family **Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.cciu.org or call (484)237-5086. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call (484)237-5086 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$0 individual/$0 family network. $1,500 individual/$4,500 family out-of-network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network: Not applicable. Out-of-network deductible does not apply to preventive care services, emergency room care, emergency medical transportation, and prescription drug coverage.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,600 individual/$13,200 family network. $10,000 individual/$30,000 family out-of-network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billing charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket limit. Out-of-network: Premiums, copayments, deductibles, balance-billing charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Will you pay less if you use a network provider?	Yes. For a list of network providers, see www.cciu.org or call (484)237-5086.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do I need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% coinsurance	----------none----------
	Specialist visit	$40 copay/visit	50% coinsurance	----------none----------
	Preventive care/Screening/Immunization	No charge for preventive care services	50% coinsurance; deductible does not apply	Age and frequency schedules may apply. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/test for x-ray; No charge for bloodwork	50% coinsurance	----------none----------
	Imaging (CT/PET scans, MRIs)	$80 copay/test	50% coinsurance	Pre-certification required for certain services. See section General Information in benefit book. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ibx.com.	Generic drugs	$5 copay/prescription (retail) $5 copay/prescription 1-30 days supply $10 copay/prescription 31-90 days supply (mail order)	No charge for drugs retail cost for amount dispensed.	Up to 34-day supply retail pharmacy for acute prescription drugs for 1 copay. Up to 90-day supply retail pharmacy for maintenance prescription drugs for 2 copays. Up to 90-day supply mail order for maintenance prescription drugs. Out-of-network: Must submit for reimbursement.
	Brand formulary drugs	$15 copay/prescription $40 copay/prescription if generic available (retail) $15 copay/prescription $40 copay/prescription if generic available 1-30 days supply $30 copay/prescription $80 copay/prescription if generic available 31-90 days supply (mail order)	No charge for drugs retail cost for amount dispensed.	
	Non-formulary brand drugs	$25 copay/prescription $40 copay/prescription if generic available (retail) $25 copay/prescription $40 copay/prescription if generic available 1-30 days supply $50 copay/prescription $80 copay/prescription if generic available 31-90 days supply (mail order)	No charge for drugs retail cost for amount dispensed.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$75 copay/visit	50% coinsurance	Pre-certification may be required. See section General Information in benefit book. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fees	No charge	50% coinsurance	Pre-certification may be required. See section General Information in benefit book. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need immediate medical attention	Emergency room Care	$100 copay/visit	$100 copay/visit; deductible does not apply	Copay not waived if admitted.
	Emergency medical transportation	No charge	No charge; deductible does not apply	----------none----------
	Urgent care	$70 copay/visit	50% coinsurance	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physician's office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copay/day (max 5 copays per admission)	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fee	No charge	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$40 copay/visit	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Inpatient services	$150 copay/day (max 5 copays per admission)	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you are pregnant	Office visits	$20 copay/visit	50% coinsurance	Office visit cost share applies to the first OB visit only. Depending on the type of services, a deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-notification requested for maternity care.
	Childbirth/delivery professional services	No charge	50% coinsurance	
	Childbirth/delivery facility services	$150 copay/day (max 5 copays per admission)	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out of Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Rehabilitation services	$40 copay/visit	50% coinsurance	20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. All visit limits combined in-network and out-of-network.
	Habilitation services	$40 copay/visit	50% coinsurance	20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. All visit limits combined in-network and out-of-network.
	Skilled nursing care	$75 copay/day (max 5 copays per admission)	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.120 visits/ benefit period. Visit limits combined in-network and out-of-network.
	Durable medical equipment	50% coinsurance	50% coinsurance	Pre-certification required for selected items. See section General Information in benefit book. 20% reduction in benefits for failure to pre-cert out-of-network or Bluecard services.
	Hospice service	No charge	50% coinsurance	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If your child needs dental or eye care	Children's Eye exam	Not covered	Not covered	----------none----------
	Children's Glasses	Not covered	Not covered	----------none----------
	Children's Dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Coverage provided outside the United States. See www.bcbsglobalcore.com.
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer at (484)237-5086.
- Independence Blue Cross at 1-800-275-2583.
- Additionally, a consumer assistance program can help you file your appeal. Contact the Pennsylvania Department of Consumer Services at 1-877-881-6388.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To obtain language assistance, call (484)237-5086.

SPANISH (Español): Para obtener asistencia en Español, llame al (484)237-5086.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (484)237-5086.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (484)237-5086.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (484)237-5086.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in network pre natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$150
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,100**

Managing Joe's type 2 Diabetes
(a year of routine in network care of a well controlled condition)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$150
Other coinsurance	0%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$510
Coinsurance	$865
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,375**

Mia's Simple Fracture
(in network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$40
Hospital (facility) copayment	$150
Other coinsurance	0%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$440**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact (484)237-5086.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese:
注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어
지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: ધ્યાન દો: જો તમે ગુજરાતી બોલતા હો, તો
ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.
1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة :إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية
متاحة لك بالمجان .اتصل برقم 2583 -275-800-1.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए
मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें
1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese:
備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。
1-800-275-2583へお電話ください。

Persian (Farsi):
توجه :اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد .با شماره 1-800-275- 2583 تماس بگیرید.

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh. H0d77lnih koj8' 1-800-275-2583.

Urdu:
توجہ درکارہے :اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں .1-800-275-2583

Mon-Khmer, Cambodian: សូមេមត្តា ចប់រមមណ៍ ៖ ប្រសិនេបើអនកនិយយភាសន-ែខមរ ឬភាែខមរ េនះ
ជំនួយែផនកភាសឥតគិតថ្លៃ ទូរសពទេទេលខ 1-800-275-25

Discrimination is Against the Law

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

This Plan provides:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan 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 can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.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*.