REQUEST FOR PROPOSALS FOR

Health Insurance Broker Services

RFP No. 21-13

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PART I

GENERAL INFORMATION TO OFFERORS

SUMMARY	
When:	Proposals must be submitted by Friday, July 16, 2021 at 2:00 PM.
Where:	Philadelphia Parking Authority Attention: Mary Wheeler, Manager Contract Administration 701 Market Street, Suite 5400 Philadelphia, PA 19106
How: **Mandatory Pre-Proposal Meeting**	Proposals must be delivered by emailing one pdf file that is password protected to Mary Wheeler, mwheeler@philapark.org by Friday, July 16, 2021 no later than 2:00 PM. The subject line of the e-mail must be "RFP No. 21-13 Health Insurance Broker Services". A hard copy will also be required and will be accepted after the due date as long as the proposal is received via email prior to Friday, July 16, 2021. A mandatory virtual Pre-Proposal Meeting will be Wednesday, June 16 at 11:00 AM via GoToMeeting. See in formation below: Pre-Proposal Meeting **Please join my meeting from your computer, tablet or smartphone.** https://global.gotomeeting.com/join/763758101 **You can also dial in using your phone.** United States (Toll Free): 1 866 899 4679 United States: +1 (312) 757-3117 **Access Code:** 763-758-101 New to GoToMeeting? Get the app now and be ready when your first meeting starts: https://global.gotomeeting.com/install/763758101 Offerors must be in attendance at this meeting to be considered an eligible Offeror. **Prospective Offerors who are having technical difficulties attending the meeting should contact Shannon Stewart for assistance, 215.837.9025.** Please complete the Offeror Registration Form the prior to the meeting.

I-1. Introduction.

This Request for Proposals ("RFP") is being issued by the Philadelphia Parking Authority, ("Authority"), a body corporate and politic created under the laws of the Commonwealth of Pennsylvania in accordance with the Act of June 19, 2001, P.L. 287, No. 22, 53 Pd. C.S. § 5501 et seq. as amended, known as the "Parking Authority Law". The Authority seeks a licensed insurance Broker and Consultant who will assist in assessing the needs and challenges of the Authority and to develop short-term and long-term solutions under a one (1) year contract with four (4) one-year extensions renewals at the sole discretion of the Authority. As a Request for Proposals, this is not an invitation to bid and although price is important, other pertinent factors will be taken into consideration.

I-2. Mission Statement.

The mission of the Philadelphia Parking Authority is to contribute to the economic vitality of Philadelphia and the surrounding region by effectively managing and providing convenient parking on the street, at the airport, and in garages and lots; effectively operating a system of red-light camera enforcement; regulating taxicabs, limousines and transportation network companies; and other transportation-related activities.

A number of customer-focused actions flow from the PPA mission:

- Improving cooperation and planning with PPA stakeholders, including state and local transportation partners,
- Implementing cutting-edge technology to improve the customer experience and enhance overall management and agency efficiency,
- Emphasizing employee training on industry best practices,
- Maximizing transparency in hiring and procurement,
- Implementing on-street parking management policies that address neighborhood needs throughout the City,
- Encouraging reasonably priced off-street parking through rate setting policies at seven PPA Center City facilities,
- Maintaining and improving neighborhood parking lots to address both residential and commercial demand,
- Providing leadership in partnering with private and public hospitality and tourism entities to enhance the visitor experience,
- Applying the latest technology for a superior customer experience at the parking facilities at Philadelphia International Airport in support of this important regional economic engine,
- Encouraging safe, clean, reliable taxicab, limousine and transportation network company service through sound regulations and consistent enforcement,
- Improving vehicle and pedestrian safety in targeted intersections through automated red light enforcement,
- Applying latest technology and continuing staff development to provide the highest quality public service with maximum efficiency.

I-3. Procurement Questions.

Prospective Offerors are encouraged to submit questions concerning the RFP in writing no later than Wednesday, June 30, 2021 at 2:00 PM. Questions concerning this RFP are to be submitted via email to Mary Wheeler at mwheeler@philapark.org with "RFP No. 21-13 Health Insurance Broker Services" listed in the subject line. Only questions submitted in writing will be addressed. The Authority will answer all questions in writing to all qualified Offerors. Any furnished answers will not be official until they have been verified, in writing, by the Authority. The Authority shall not be bound by any verbal information nor shall it be bound by any written information that is not either contained within the RFP or formally issued as an addendum by the Authority. The Authority does not consider questions to be a protest of the Work Statement or of the solicitation.

I-4. Clarification of Instructions.

Should the prospective Offeror find a discrepancy in or an omission from the Work Statement or any part of this RFP, or should he or she be in doubt as to the meaning of any term contained therein, the Offeror shall notify Mary Wheeler, Manager of Contract Administration via email at mwheeler@philapark.org prior to the question deadline. All questions

and clarification requests will be responded to via written addendum that will be emailed to all registered Offerors. Addenda will also be posted to the Authority's website, www.philapark.org.

I-5. Restrictions of Contact.

From the issue date of this RFP until the Authority's Board approves the awarding of the contract, **Mary Wheeler is the sole point of contact concerning this RFP**. Any violation of this condition by an Offeror may result in the Authority rejecting the offending Offeror's proposal. If the Authority later discovers that the Offeror has engaged in any violations of this condition, the Authority may reject the offending Offeror's proposal or rescind its award. Offerors must agree not to distribute any part of their proposals beyond the Authority. An Offeror who shares information contained in its proposal with other Authority personnel and/or competing Offeror personnel may be disqualified.

I-6. Proposal Conditions.

Proposals must be delivered by emailing one pdf file that is password protected to Mary Wheeler, mwheeler@philapark.org by Friday, July 16, 2021 no later than 2:00 PM. The subject line of the e-mail must be "RFP No. 21-13 Health Insurance Broker Services". A hard copy will also be required and will be accepted after the due date as long as the proposal is received via email prior to Friday, July 16, 2021 at 2:00 PM. Each Offeror shall submit to the Authority the information and forms required, which forms and information shall become the property of the Authority and will not be returned to Offerors, unless a written request to withdraw is received prior to the opening of proposals. Failure to attach documents required for submittal at the time of submittal will result in the offer being rejected.

I-7. Small and Small Diverse Business Requirements.

The Authority is continually looking for opportunities available for growth and advancement among small and small diverse business through contracts to provide products, services or construction to the Authority. Offerors shall identify their status as a small and diverse business by completing the Small and Small Diverse Business Participation Submittal form included in the Proposal Form along with a copy of their Small Business Procurement Initiative certificate issued from the Pennsylvania Department of General Services. Offerors may self-certify at:

http://www.dgs.pa.gov/Businesses/Small%20Business%20Contracting%20Program/Pages/default.aspx,

http://www.dgs.pa.gov/Businesses/Small%20Diverse%20Business%20Program/Small-Diverse-Business-Verification/Pages/default.aspx.

I-8. Signatures Required.

The proposals *must* be signed in all spaces where signatures are required. In cases of corporation, the signature must be that of a duly authorized officer of the corporation and officer's title must be stated. In cases of partnerships, the signature of a general partner must follow the firm name, using the term "On Behalf of the General Partner." In cases of an individual use the term "dba" (Company Name) or as sole owner.

I-9. Instructions for Affidavit of Non-Collusion.

1. The Non-Collusion Affidavit is material to any contract awarded through a public solicitation.
2. This Non-Collusion Affidavit must be executed by the member, officer or employee of the offeror who makes the final decision on terms and prices identified in the proposal.
3. Bid rigging or collusion and other efforts to restrain competition, and the making of false sworn statements in connection with the submission of bids are unlawful and may be subject to criminal prosecution. The person who signs the Affidavit below should examine it carefully before signing and assure himself or herself that each statement is true and accurate, making diligent inquiry, as necessary, of all other persons employed by or associated with the offeror with responsibilities for the preparation, approval or submission of the proposal.
4. In the case of a proposal submitted by a joint venture, each party to the venture must be identified in the proposal documents, and an Affidavit must be submitted separately on behalf of each party.

5. The term "complementary proposal" as used in the Affidavit has the meaning commonly associated with that term in the request for proposal process, and includes the knowing submission of proposals higher than the proposal of another firm, any intentionally high or noncompetitive proposal, and any other form of proposal submitted for the purpose of giving a false appearance of competition.
6. Failure to file and attach an Affidavit in compliance with these instructions will result in disqualification of the proposal.

I-10. Insurance Requirements.

The successful Offeror will be required to submit Insurance Coverage as outlined in *Appendix C*. Offeror's must submit with their proposal a sample certificate of insurance from a recent project that meets the requirements. If you do not currently carry the level of insurance that is required you must submit a letter from your insurance company indicating that they will provide the required insurances as outlined in this RFP if awarded a contract. **Insurance requirements will not be negotiated after the proposal due date**.

I-11. Executed Contract Required.

By submitting a proposal in response to this RFP the Offeror agrees that the Authority will not be bound to any contract, performance or payment obligation until the Authority's Board votes to award a contract to the successful Offeror and the Authority's Executive Director signs the written contract.

I-12. Contract Negotiation.

If successful, this procurement process will result in the presentation of a completed final-form contract to the Authority's Board for approval at a public meeting. To advance that goal a sample contract is included as *Appendix B*. Please review the sample contract carefully. Any exceptions or requested changes to the contract **must be clearly noted in the proposal (Tab G)** in order to be considered.

Exceptions or requested changes to the sample contract will be considered a **part of the response.** Exceptions or requested changes to the sample contract should be made with great care. The Authority may reject all or some of those changes or exceptions, in its sole discretion.

I-13. Business Licenses:

The proposal should include the Offeror's Philadelphia Commercial Activity License (formerly Business Privilege License) number and the Offeror's Federal Tax ID number if the Offeror is seeking representation of the Authority in Philadelphia. If the Offeror does not currently have a Philadelphia Commercial Activity License, it must obtain one no later than five business days after the Board awards the contract. If the Offeror does not believe that it needs a Philadelphia Activity License, an explanation with references to statute and/or the Philadelphia Code should be included with the proposal.

I-14. Rejection or Acceptance of Proposals.

An Evaluation Committee comprised of Authority employees will review all proposals. Discussions and negotiations may be conducted with responsible Offerors for the purpose of clarification and of obtaining best and final offers. Responsible offers shall be accorded fair and equal treatment with respect to any opportunity for discussion and revision of proposals. In conducting discussions, there shall be no disclosure of any information derived from proposals submitted by competing Offerors.

The responsible Offeror whose proposal is determined in writing to be the most advantageous to the Authority, taking into consideration price and all evaluation factors, shall be selected for contract negotiation. In the event the negotiations reveal that the proposal selected for negotiation is not the most advantageous or the Offeror selected for negotiation defaults or withdraws from negotiation, the Evaluation Committee may select another proposal then determined to be the most advantageous to the Authority, taking into consideration price and all evaluation factors, for contract negotiation. The Authority may cancel the RFP and reject all proposals at any time prior to award by the Board.

The Authority reserves the right to waive any irregularities in the completion of the forms and papers enclosed in this schedule; to accept or reject any or all proposals; to re-advertise for proposals if desired, and to accept any proposal which, in the judgment of the Authority, will be in the Authority's best interest.

Any form which is required to be submitted and which is incomplete, conditional, obscure, contains additions not called for and not approved by the Authority, or which contains irregularities of any kind, may be cause for rejection of the proposal, in the sole discretion of the Authority. At any time up to the hour and date set for opening of proposals, an Offeror may withdraw its proposal. Such withdrawal must be in writing and sent to the Authority at the address set forth herein by a nationally recognized overnight courier service, certified mail, return receipt requested, or delivered in person. Such withdrawal shall be effective only upon receipt by the Authority evidenced by written confirmation of such receipt and will preclude the submission of another proposal by such Offeror. After the scheduled time for opening of proposals, no Offeror will be permitted to withdraw their proposal, and each Offeror hereby agrees that their proposal shall remain firm for the contract period. A proposal made and opened may be withdrawn with the written permission of the Authority, if the Authority determines in its sole discretion that the proposal is inconsistent with the best interest of the Authority.

I-15. Unacceptable Proposals.

No proposal will be accepted from or selection made of any person, firm or corporation that is in arrears or in default to the Authority upon any debt or contract, or whose insurer or banking institution is in default as surety or otherwise upon any obligation to the Authority, or has failed in the sole opinion of the Authority to faithfully perform any previous contract with the Authority.

I-16. Subcontracting.

Any use of subcontractors by an Offeror must be identified in the proposal. During the contract period, use of any subcontractors by the selected Offeror, which were not previously identified in the proposal, must be approved in advance in writing by the Authority.

I-17. Notification of Offeror Selection.

The Authority will study and evaluate all proposals which are received in accordance with the instructions set forth in the proposal package and may select an Offeror or multiple Offerors and notify all other Offerors of the selection within sixty (60) days after the date the proposals are opened. Such notice shall be in writing and mailed to the address furnished by each respective Offeror in the Transmittal Letter. The selected Offeror(s) shall not start the performance of any work prior to the effective date of the Contract and the Authority shall not be liable to pay the selected Offeror for any service or work performed or expenses incurred before the effective date of the Contract. Costs incurred by the Offeror in the preparation of the proposal or during any review or negotiations shall be born exclusively by the Offeror.

I-18. Standard Practices.

All work performed under the contract shall be subject to inspection and final approval by the Authority, through the Executive Director or his designee.

I-19. Document Disclosure.

While documents exchanged by or with the Authority or its agents during this process may be protected from public release by certain terms of Pennsylvania's Right to Know Law (65 P.S. §§67.101–67.3104), Pennsylvania's Procurement Code, or other laws, many documents may not be protected. All Offerors are advised to seek counsel or otherwise educate themselves regarding open records laws and regulations in Pennsylvania.

I-20. Statement of No Proposal.

All Prospective Offerors that do not intend to submit a proposal are asked to complete the Proposal Decline Form enclosed in the proposal documents. This document must be emailed to the attention of Mary Wheeler, Manager of Contract Administration at mwheeler@philapark.org. Specific comments and observations are encouraged.

I-21. Shipping and Delivery.

The Offeror will be responsible for all shipping and delivery costs of the specified items required to support the proposal.

PART II

INFORMATION REQUIRED FROM OFFERORS

II-1. Proposal Format.

All proposals submitted must conform to the following format requirements. A transmittal letter signed by a person authorized to engage the Offeror in a contract must be included in your proposal. Proposals must be submitted on letter size (8 ½" x 11") paper. The point size font for text must be 10 to 12, and 6 to 8 for exhibits. All documents must contain a one-inch margin. For exhibits, 11x17 paper is acceptable. An electronic version of the Proposal Form can be provided to all prospective Offerors upon request. Forms that are altered by the offeror may be grounds for rejection of the Offerors response.

The tab requirements are as follows:

Tab A - Transmittal Letter
Tab B – Qualifications and Experience
Tab C - References
Tab D - Proposal Form & Cost Proposal
Tab E – Technical Response
Tab F - Insurance Requirements
Tab G - Proposed Amendments to Contract
Tab H - Financial Statements

II-2. Transmittal Letter (Tab A).

Offerors shall submit a cover letter, signed by an authorized principal or agent of the company, which provides an overview of the Offeror's proposal, as well as the name, title, email address and phone number of the person to whom the Authority may direct questions concerning the proposal. Include a statement by the Offeror accepting all terms and conditions contained in this RFP, signed by an officer or individual with authority to bind the firm.

II-3. Qualifications and Experience (Tab B).

Offerors must have a minimum of seven (7) years' experience in providing the services described in this RFP.

Offerors are to provide a summary of their experience with health plan analysis and design representing organizations, as described in the Work Statement, including government agencies, non-profits and educational institutions in the Commonwealth of Pennsylvania within the past five years.

This summary must include your firm's experience in benefits consulting as described in the Work Statement, provide detailed resumes of persons proposed to work directly with the Authority and indicate the level of responsibility of each person (professional staff only).

Resumes are to include educational qualifications and previous work assignments that relate to this RFP. The primary employee anticipated to represent the Authority must be named. Include any personnel or services that set you apart from other health insurance brokers or reasons why it would be most advantageous for the Authority to contract with you.

II-4. References (Tab C).

A minimum of three (3) references, to whom similar services were provided within the last 3 years. The client references must include the name of the organization, address, email address, telephone number, individual contact person, the dates services were performed and a description of the services provided.

II-5. Proposal Form and Fee Proposal (Tab D):

The proposal form contained within this RFP must be submitted in its entirety (except the proposal decline form). All signature lines must be executed in ink (on the original only).

The proposal shall provide an annual fixed fee (zero commissions) to include all services outlined in the work statement. The fee will be payable by the Authority in twelve equal monthly installments, in arrears. The term of the contract will be one year, with four annual one-year renewals at the Authority's sole discretion. If the Offeror seeks a different fee for any of the five one-year terms, they should be clearly identified in the proposal. Fees will not be negotiated after the contract award.

The consultant's only permitted source of income, revenue or compensation earned in connection with any Authority account is the annual fixed flat rate paid by the Authority. Any other source of income, revenue, consideration or compensation, including, but not limited to, commissions and overrides received by the consultant in connection with an Authority account, must be disclosed and remitted to the Authority or subtracted from the annual fee proposed.

II-6. Technical Response (Tab E).

Offeror shall demonstrate a complete understanding of the Authority's requirements, demonstrate their ability to meet all requirements and outline a clear and concise plan to meet the requirements.

II-7. Insurance Requirements (Tab F).

The successful Offeror will be required to submit Insurance Coverage as outlined in *Appendix C*. Offeror's must submit with their proposal a sample certificate of insurance from a recent project that meets the requirements. If you do not currently carry the level of insurance that is required you must submit a letter from your insurance company indicating that they will provide the required insurances as outlined in this RFP if awarded a contract. **Insurance requirements will not be negotiated after the proposal due date**.

II-8. Proposed Amendments to Contract (Tab G).

If successful, this procurement process will result in the presentation of a completed final-form contract to the Authority's Board for approval at a public meeting. To advance that goal a sample contract is included for review as *Appendix B.* Please review the sample contract carefully. Any exceptions or requested changes to the contract **must be clearly noted in the proposal** in order to be considered.

II-9. Financial Statements (Tab H).

Offeror must provide complete financial statements for the last three years, which have been audited or reviewed by an independent Certified Public Accountant who is not an employee of the Offeror. Complete financial statements must include, at a minimum, a balance sheet, income statement, reconciliation of equity, and a cash flow statement. Offeror may only submit one copy of their financial statements either with the original proposal or in a separate envelope marked "confidential".

Provide a summary and the status of any current or ongoing legal actions, suits, proceedings, claims or investigations pending with any governmental agency with which the Offeror has had or currently has a contractual relationship. The existence of any such pending actions, suits, proceedings, claims or investigations may be a factor considered by the Authority in determining which Offeror should be awarded that contract but will not automatically disqualify the Offeror from consideration. Should there be no legal actions, suits, proceedings, claims or investigations pending with any

governmental agency with which the Offeror has had or currently has a contractual relationship, a statement to that effect will be included.

PART III

CRITERIA FOR SELECTION

III-1. Mandatory Responsiveness Requirements. To be eligible for selection, a proposal shall be (a) submitted by an Offeror who was represented at the mandatory pre-proposal meeting; (b) timely received from an Offeror; (c) properly signed by the Offeror.

III-2. **Technical Nonconforming Proposals.** The three (3) Mandatory Responsiveness Requirements set forth in Section III-1 above are the only RFP requirements that the Authority will consider to be non-waivable. The Authority reserves the right, in its sole discretion, to waive any other technical or immaterial nonconformities in the proposal, allow the Offeror to cure the nonconformity, or consider the nonconformity in the evaluation of the proposal.

III-3. Proposal Evaluation. Proposals will be reviewed, evaluated and rated by an Evaluation Committee consisting of Authority employees. The Authority will select the most highly qualified Offeror or the Offeror whose proposal is determined to be most advantageous to the Authority as determined by the criteria listed below.

During the evaluation process, the Authority may require an Offeror to answer questions with regard to the proposal and/or require certain Offerors to make formal presentation to the Evaluation Committee.

III-4. Evaluation Criteria. The Authority determined that it is not advantageous for it to use a bidding process in order to secure the services of detailed in this RFP because it wished to consider criteria other than price in the award process, in particular, the Offeror's qualifications and experience.

Proposals will be evaluated consistent with the requirements of this RFP and determine the most responsive Offerors as follows:

a. Responsiveness of the proposal to the submission requirements set forth in the RFP. **Weight: 10%**

b. Qualification and experience of the Offeror with regard to the Work Statement outlined in the RFP. **Weight: 30%**

c. The technical ability and capacity of the Offeror to meet the terms of the contract as evidenced by technical response, reference feedback, financial capacity and past performance. **Weight: 30%**

d. Proposed fees, costs, and changes to the proposed contract although the Authority is not bound to select the Offeror who proposes the lowest fees. **Weight: 20%**

e. Small and Small Diverse Business participation. **Weight: 10%**

PART IV

WORK STATEMENT

IV-1. General.

The Philadelphia Parking Authority ("Authority") seeks the services of a benefits consultant with significant experience representing a broad range of clients, particularly those in the public sector to negotiate all group benefit contracts and to solicit competitive quotes from prospective carriers.

IV-2. Specific.

The successful Offeror will provide the following benefit consulting services for employee benefit programs to include, but not be limited to the following:

1. Review and make recommendations regarding existing benefit plans, modifications to the existing plan design, cost (rates) and potential benefit plans and options. Recommendations will be presented to the Authority for consideration three months prior to expiration of each policy.
2. Review market trends and conduct a cost analyses against the Authority's current benefit plans.
3. Review the Authority's benefits programs on a continuing basis to ensure that the plans are compliant with governmental regulations and assist with compliance reporting.
4. Provide assistance with benefit issues related to coverage, claims, billing and other related matters that may arise during the normal course of business.
5. Alert the Authority regarding benefits information that may need to be distributed to employees, deadlines associated with said communication, and provide sample documents to be used to notify employee of any changes.
6. Provide detailed reporting regarding desired insurance packages and potential carriers to include an analysis of proposals and recommendations.
7. Assist and advise the Authority in contract negotiations with benefit plan providers on matters including, but not limited to, premium rates, benefit levels, performance standards and guarantees, contractual terms and conditions, quality assurance standards, utilization and performance reports, statistical and/or financial reports, and plan specific data such as medical conditions, prescription drugs, high-cost procedure, in-patient data, etc.
8. Provide consulting and guidance with respect to government mandates such as FMLA, COBRA, HIPPA, ADA, ACA, USERRA, etc.
9. Provide open enrollment support including, but not limited to, developing timeline, assisting with the development of open enrollment materials, developing and printing sufficient copies of a benefit summary guide, coordinating and participating in open enrollment meetings as reasonable requested.
10. Identify a key contact person to be available to answer questions and resolve issues that arise during the contract period regarding employee benefits packages.
11. Assist the Authority in gathering information from carriers to satisfy internal audits of benefit plans, for example Other Post-Employment Benefit (OPEB) liability data.
12. Provide stop-loss analysis every six month for review. This will ensure we are aware of our cost trend for stop loss.
13. Provide quarterly claims reporting and analysis at least 10 days after the close of each quarter. Quarterly claims reporting and analysis will be provided to the Authority staff either in person or via formal teleconference.

14. Generate reports, for utilization and analyzation of benefit programs including, but not limited to health, prescription drug, vision, dental, stop loss and Medicare supplement to compare current and prior year data.
15. Provide network match and employee disruption analysis reports.
16. Assist the Authority with the development of a robust wellness program.

These are minimum expectations. The Authority anticipates that professionals responding to this RFP will provide additional insight, if necessary.

QUESTIONNAIRE

Benefits Consultant: All proposals must contain written responses to the following questions or requests for information.

1. Briefly describe your organization and governance structure. Include your experience and qualifications in servicing large groups and carrier alliances. Describe your experience with organizations of similar size, makeup and demographic which may or may not include public entities.
2. Confirm that you serve as a consultant or broker, independently, and are not affiliated with any insurance company, third party administrative agency or provider network.
3. Provide a statement of assurance to the effect that your firm is not currently in violation of any regulatory rules and regulations that may have an impact on your firm's operations.
4. Provide background, industry affiliations and credentials of key management.
5. Outline your ability to negotiate all group benefit contracts of the Authority and to solicit competitive quotes from competing carries.
6. Provide a detailed description of how you can maintain current carrier relationships.
7. Define your marketplace expertise and your ability to negotiate the best rates with existing and alternative carriers.
8. Outline your ability to provide expertise and experience in the areas of health benefits plan analysis and design. Explain in detail the types of analysis you conduct.
9. Describe your expertise in vendor management and auditing, specifically in regard to Third Party Administrators (TPAs).
10. Describe your ability to perform stop-loss analysis.
11. Describe your support before, during and after Open Enrollment.
12. Describe what type of employee communications and education support your company provides? Is this an in-house service or outsourced?
13. Describe how your company will support our organization's efforts to comply with all relevant Health and Welfare Benefits regulation? Describe how you ensure that your clients are kept in compliance, and what type of resources are/would be available for the Authority (e.g. filing 1095 form).
14. Describe your knowledge of Healthcare Reform legislation and how you will support us in keeping current with its details and compliant with its regulations.
15. Describe what assistance is provided by your organization for the training and development of our staff on compliance issues. Describe your experience with FMLA, ADA ACA, COBRA , COVID-19, USERRA etc.
16. Describe your experience with FMLA, ADA ACA, COBRA , COVID 19, USERRA etc.
17. Attach a sample insurance renewal proposal your firm prepared for a client of similar size and complexity of the Authority. You may redact any identifying information deemed proprietary to that client.
18. Attach a sample of claims/analysis/stop-loss reporting that you have prepared for a similar client of size and complexity of the Authority. You may redact identifying information deemed proprietary to that client.
19. Identify what added value your firm will provide access to beyond your firm's internal expertise (e.g. pharmacy specialist).

CURRENT BENEFIT PLANS

Healthcare
Independence Blue Cross (plan administrator)
HM Insurance (stop-loss provider integrated with prescription drug)
Incumbent carrier since April 1, 2006
Benefit plan self-funded since April 1, 2015
Contract expires April 1, 2022
Approximately 600 Current and Retirees

Prescription Drug
Future scripts (Plan Administrator)
Incumbent carrier since 2018
Contract expires: 03/31/2022
Approximately 640 Current and Retirees

COBRA
COBRA-Meritain Health (Plan COBRA Administrator)
Incumbent carrier since 4/1/2016
Contract expires: 03/31/2022

Dental
Delta Dental of Pennsylvania
Incumbent carrier since January 1, 2012
Benefit plan self-funded since April 1, 2016
Contract expires March 31, 2022
Approximately 675 Current and Retirees

Vision Care
Vision Benefits of America
Incumbent carrier since April 1, 2006
Benefit plan fully insured
Contract expires March 31, 2022
Approximately 675 Current and Retirees

Life and Disability
CIGNA
Incumbent carrier since April 1, 2014
Benefit plan fully insured
Contract expires March 31, 2023
Approximately 986 Current, Union and Retirees

Retiree Medical Plan
The Hartford (medigap supplement provider)
Benistar (plan administrator)
Incumbent carrier since January 1, 2014
Benefit plan fully insured since January 1, 2014
Contract expires December 31, 2021
Approximately 105 Retirees

Group Life Insurance

Class 1: 1.5 times annual salary rounded to highest thousand dollars; cap of $250,000
Class 2: $25,000 flat benefit amount
Class 3: $30,000 flat benefit amount
Class 4: $8,000 flat benefit (District Council 33 employees who retired before 2005)
Class 5: $12,000 flat benefit (District council 33/47 employees who retired after 2005)

Group Short-Term Disability

Class 1: Benefit amount – lesser of $400 per week or 60% of weekly wage
Benefit period – 52 weeks
Elimination period – 14 days

Class 2: Benefit amount - $300 per week flat benefit
Benefit period – 26 weeks
Elimination period – 7 weeks

Group Long-Term Disability

Class 1: Benefit amount – 60% of monthly wage, cap of $5,000
Benefit period – Normal social security retirement age
Elimination period – 52 weeks
Definition of disability – own occupation 2 years, any occupation after 2 years

PART V

CONTRACT TERMS AND CONDITIONS

V-1. Sample Contract. A sample contract is attached to this solicitation as *Appendix B*. Please review the sample contract carefully. Any exceptions or requested changes to the contract **must be clearly noted in the proposal (Tab G)** in order to be considered.

Exceptions or requested changes to the sample contract will be considered a part of the response. Exceptions or requested changes to the sample contract should be made with great care, because the number of changes made or the need for subsequent negotiations will factor into the scoring of the proposal.

The Authority's Contractor Integrity Provisions are attached to the proposed form of contract as Exhibit "A". Those Provisions apply to every Authority contractor and any party seeking to contract with the Authority. By submitting a proposal to this public procurement process the potential contractor agrees to comply with the Contractor Integrity Provisions.

V-2. Contract Term. The term of the contract shall commence upon award of a contract by the Authority's Board at a public meeting and execution of a contract by the Executive Director and shall end one (1) year after with the option of four (4) one-year renewals at the sole discretion of the Authority.

Appendix A

Proposal Form

THE PHILADELPHIA PARKING AUTHORITY
701 MARKET STREET – SUITE 5400
PHILADELPHIA, PA 19106

HEALTH INSURANCE BROKER SERVICES
RFP No. 21-13

PROPOSAL FORM

1. The undersigned submits this proposal in response to the above referenced **RFP No. 21-13 Health Insurance Broker Services** being familiar with and understanding the advertised notice of opportunity, General Information, Work Statement, Proposal Form, Affidavit of Non-Collusion, and Addenda if any (the "Proposal Documents"), as prepared by the Philadelphia Parking Authority and posted on the Authority's Internet website and on file in the office of the Authority at 701 Market Street, Suite 5400, Philadelphia, PA 19106. The party submitting a proposal is the "Offeror".

2. The Authority reserves the right to withdraw and cancel this RFP prior to opening or to reject any and all proposals after proposals are opened if in the best interest of the Authority, in the Authority's sole discretion. If the Authority accepts Offeror's offer, Offeror agrees to execute a contract memorializing the proposal's terms if the contract is delivered to Offeror within 60 days of the proposal opening date. This provision will not be interpreted to preclude the execution of a contract related to this proposal outside of that 60 day period.

3. Offeror acknowledges receipt of the following addenda:

Addendum	Date
_____	_____
_____	_____
_____	_____

4. **Contract Term.** The term of the contract shall commence upon award of a contract by the Authority's Board at a public meeting and execution of a contract by the Executive Director and shall end one (1) year thereafter, unless it is terminated earlier pursuant to the terms of the contract. The term of the contract may be extended by and at the sole option of the Authority for up to four (4) additional one (1) year terms.

5. **Cost Proposal:** Include in Tab D, the cost proposal for the annual fixed fee (zero commissions) to include all services outlined in the work statement and the offerors proposal. The fee will be payable by the Authority in twelve equal monthly installments, in arrears. The consultant's only permitted source of income, revenue or compensation earned in connection with any Authority account is the annual fixed flat rate paid by the Authority. Any other source of income, revenue, consideration or compensation, including, but not limited to, commissions and overrides received by the consultant in connection with an Authority account, must be disclosed and remitted to the Authority or subtracted from the annual fee proposed.

6. **Requirement Statement:** The undersigned Offeror agrees to provide health insurance broker services as specified in the Work Statement, any Addenda, if issued and the response submitted.

_____
Signature

_____
Name
(Please Print)

_____
Title

_____
Date

7. Offeror Signatures: Complete one section below.

If proposal is by a corporation, form must include the date and be signed here by (a) President or Vice President, and (b) Secretary, Assistant Secretary, Treasurer, Assistant Treasurer, or Officer. If this form is not so signed, a corporate resolution authorizing form of execution must be attached to this proposal.

Signature	Signature
Typed or Printed Name	Typed or Printed Name
Title	Title
Business Name of Offeror	
Street Address	
City/State/ZIP Code	
Email Address	
Telephone Number	Date

If offer is by a business entity other than a corporation form must be dated and signed here:

Authorized Signature	Business Name of Offeror
Typed or Printed Name	Street Address
Title	City/State/ ZIP Code
Date	Telephone Number
Type of Entity	

8. Affidavit of Non-Collusion:

State of: _____ RFP No. _____
County of: _____

I state that I am _____ (Title) of _____ (Name of my organization) and that I am authorized to make this affidavit on behalf of my firm, and its owners, directors, and officers. I am the person responsible in my firm for the price(s) and the amount of this proposal and I have placed my signature below.

I state that:

(1) The price(s) and amount of this proposal have been arrived at independently and without consultation, communication or agreement with any other contractor, Offeror or potential Offeror.

(2) Neither the price(s) nor the amount of this proposal, and neither the terms nor the approximate price(s) nor approximate amount of this proposal, have been disclosed to any other firm or person who is an Offeror or potential Offeror, and they will not be disclosed before proposal opening.

(3) No attempt has been made or will be made to induce any firm or person to refrain from submitting a proposal in response to this Proposal, or to submit a proposal higher than this proposal, or to submit any intentionally high or noncompetitive proposal or other form of complementary proposal.

(4) The proposal of my organization is made in good faith and not pursuant to any agreement or discussion with, or inducement from, any firm or person to submit a complementary or other noncompetitive proposal. I have read, understand and will abide by the Authority's Contractor Integrity Provisions.

(5) _____ (my organization's name) its affiliates, subsidiaries, officers, directors and employees are not currently under investigation by any governmental agency and have not in the last four years been convicted or found liable for any act prohibited by State or Federal law in any jurisdiction, involving conspiracy or collusion with respect to bidding on any public contract, except as follows:

I state that _____ (my organization's name) understands and acknowledges that the above representations are material and important and will be relied on by The Philadelphia Parking Authority when awarding the contract for which this proposal is submitted. I understand and my organization understands that any misstatement in this affidavit is and shall be treated as fraudulent concealment from The Philadelphia Parking Authority of the true facts relating to the submission of proposals / proposals for this contract.

_____
Signature

SWORN TO AND SUBSCRIBED
BEFORE ME THIS _____DAY
OF 20___

_____
Printed Name

_____
Notary Public
My Commission Expires: _____

9. Qualifications:

a.	**Type of business**:	Individually owned	□
	Check one	Partnership	□
		Corporation	□
		Other	□
b.	**Number of employee**s:	Under 25	□
	Check one	Under 50	□
		Under 100	□
		Over 100	□

c. **If you have had previous contracts with the Authority, list date and product or service provided**:

i.....

ii.....

iii.....

d. **Philadelphia Business Activities License Number**: **_____**

e. **Federal EIN Number:_____**

INTENTIONALLY

LEFT BLANK

Philadelphia Parking Authority

SMALL AND SMALL DIVERSE BUSINESS PARTICIPATION SUBMITTAL

RFP Name and Number: _____

Offeror: _____

Contact Name: _____ Email: _____

OFFEROR INFORMATION:

Does the Offeror hold a Small Business Procurement Initiative certificate issued by the Pennsylvania Department of General Services? □ Yes □ No (MUST check one)

If yes, please identify each category that applies to your business:

1. _____.
2. _____.
3. _____.
4. _____.
5. _____.

The Offeror will need to attach a copy of their SBPI certificate. Offeror will be required to maintain their status as a certified Small and Diverse Business throughout the entire term of the contract.

MANAGER CONTRACT ADMINISTRATION
THE PHILADELPHIA PARKING AUTHORITY
701 MARKET STREET, SUITE 5400
PHILADELPHIA, PA 19106

Proposal Decline Form: RFP No. 21-13 Health Insurance Broker Services

If you did not submit an offer to the Authority for this solicitation, please return this form immediately.

The undersigned contractor declines to submit an offer for this project.

Name: _____

□ Requirements too "tight" (explain below)
□ Unable to meet time period for responding to this Proposal
□ We do not offer this product or service
□ Our schedule would not permit us to perform
□ Unable to complete Work Statement
□ Unable to meet Bond/Insurance Requirements
□ Work Statement unclear (explain below)
□ Unable to meet Insurance Requirements
□ Unable to meet Contract Requirements (explain below)
□ Other (specify below)

Comments:

Upon completion of this form, please email the form to Mary Wheeler, Manager of Contract Administration at mwheeler@philapark.org.

Appendix B

Sample Contract

AGREEMENT FOR HEALTH INSURANCE BROKER SERVICES
BY AND BETWEEN
THE PHILADELPHIA PARKING AUTHORITY
AND _____

Contract No. K-21-00___

THIS AGREEMENT effective as of the ____ day of _____, 2021 by and between **The Philadelphia Parking Authority**, an agency of the Commonwealth of Pennsylvania and a body corporate and politic, with its principal address at 701 Market Street, Suite 5400, Philadelphia, PA 19106 (the **"Authority"**) and _____ with a registered address at _____, _____, ___ _____ (**"Company"**).

WITNESSETH:

WHEREAS, the Authority, a public body corporate and politic organized and existing under the Act of 2001, June 19, P.L. 287, No. 22, as amended;

WHEREAS, the Authority sought the services of a benefits consultant with significant experience representing a broad range of clients, particularly those in the public sector to negotiate all group benefit contracts and to solicit competitive quotes from prospective carriers through Request for Proposal No. 21-13 "Health Insurance Broker Services" (hereinafter "RFP"), a true and correct copy of the RFP is attached hereto as Exhibit "B"; and

WHEREAS, upon review of Company's Proposal responding to the RFP submitted to the Authority on _____, ("Proposal") the Authority's Board voted at a public meeting to award this contract to Company.) A true and correct copy of the Proposal is attached hereto as Exhibit "C".

NOW, THEREFORE, in consideration of the covenants and conditions contained herein, intending to be legally bound, the parties hereto hereby agree as follows:

1. SERVICES.

The Authority hereby engages and Company hereby agrees to provide services ("Services") as provided below:

A. To provide Services identified in the Proposal in the most cost effective manner utilizing personnel at the level of competence required relative to the nature of the work, and to follow all applicable federal, state, or local laws; and

B. To coordinate the fulfillment of this Agreement with the Authority's Project Manager for the implementation of the Services. The Authority's Project Manager shall be Saraann Haglund, who may be reached at 215-683-9869 or by e-mail at SHaglund@philapark.org. However, the parties agree that only the Authority's Board or Executive Director may consent to any alteration or amendment to this Agreement, and in each such case in writing.

C. To comply fully with all requirements and terms of this Agreement, the RFP and the Proposal.

2. TERM. The term of this Agreement shall commence on the date first written above and shall end 1 year thereafter, with 4 one-year Options to Renew at the sole discretion of the Authority, subject to the other provisions of this Agreement. The Authority shall provide 30 days written notice of its option to renew for each one-year term permitted by this Agreement. The term of this Agreement may not be extended beyond 5 years.

3. CONSIDERATION AND PAYMENT.

A. For the provisions of Services described herein, the Authority shall pay the Company in accordance with Section _____ of its _____(date) Proposal ("Fixed Fee"). Company agrees to accept such amounts resulting from the Services performed as the sole and full compensation for such Services.

B. The Company shall invoice the Authority monthly and in arrears for payment for Services as provided in this Agreement in a form acceptable to the Authority. All invoices shall be forwarded to _____at the Authority's address provided above.

C. At no time will Company be reimbursed for any administrative or overhead costs incurred by Company in fulfilling the terms of this agreement, including, but not limited to, any time, fees or expenses associated with Company's travel, fuel, lodging, food, or photocopying in connection with Company's Services without the advanced written approval of the Project Manager.

D. Company's only permitted source of income, revenue or compensation earned in connection with this Agreement is the annual Fixed Fee paid by the Authority. Any other source of income, revenue, consideration or compensation, including, but not limited to, commissions and overrides received by Company in connection with this Agreement must be disclosed to the Authority and remitted to the Authority or subtracted from the annual Fixed Fee.

4. NO SOLICITATION/CONFLICTS OF INTEREST.

A. Company does hereby warrant and represent that the laws of the Commonwealth of Pennsylvania have not been violated as they relate to the procurement or performance of this Agreement by any conduct, including payment or giving of any fee, commission, compensation, gift, gratuity or consideration of any kind, directly or indirectly to any Authority employee, officer or Company.

B. To the best of Company's knowledge, no Authority member or officer, and no employee of the Authority has any interest (whether contractual, non-contractual, financial or otherwise) in this transaction or in the business of Company. If such transaction comes to the knowledge of the Company at any time, a full and complete disclosure of such information shall be made to the Authority.

C. Company hereby acknowledges receipt and acceptance of the Authority's Contractor Integrity Provisions attached hereto as Exhibit "A". Company, for itself, its agents and employees

agrees to adhere to the Contractor Integrity Provisions and understands that failure to do so may result in the cancellation of this contract and the reporting of any offending event for investigation.

5. INABILITY OF COMPANY TO PERFORM. The inability of Company to perform or provide the Services under this Agreement, for any reason, shall automatically terminate this Agreement, whereupon all liabilities or obligations for payment hereunder shall terminate as of the date of such termination.

6. TERMINATION FOR CONVENIENCE OF AUTHORITY. The Authority and Company agree that this Agreement may be terminated by the Authority with or without cause upon five (5) days' notice in writing by the Authority to Company. If the Agreement is terminated by the Authority, as provided herein, Company will be paid any compensation outstanding for the Services satisfactorily performed pursuant to Section 3 herein for the period prior to the date of termination. In such event, all memoranda, records, data, information and other documents prepared by Company shall become the property of the Authority and shall be forthwith delivered to the Authority. The payments to be made to Company hereunder are the Company's sole remedy and right with respect to termination under this paragraph.

7. GENERAL TERMS AND CONDITIONS.

A. Right to Know Law Provisions.

1. The Pennsylvania Right-to-Know Law, 65 P.S. §§ 67.101-3104, ("RTKL") applies to this Agreement.

2. If the Authority requires the assistance of the Company as to any request or other issue related to the RTKL in regard to this Agreement ("Requested Information"), it will notify the Company using the contact information provided in this Agreement. Upon written notification from the Authority that it requires the Company's assistance in responding to such a request under the RTKL the Company must:

i. Provide the Authority, within 5 days after receipt of written notification, with copies of any document or information in the Company's possession arising out of this Agreement that the Authority reasonably believes is Requested Information and may be a public record under the RTKL; and

ii. Provide such other assistance as the Authority may reasonably request, in order to comply with the RTKL with respect to this Agreement.

3. If the Company considers the Requested Information to be exempt from production under the RTKL, the Company must notify the Authority and provide, within 5 days of receiving the written notification, a written statement signed by a representative of the Company explaining why the requested material is exempt from public disclosure under the RTKL and identifying the specific provision of the RTKL that renders some or all of the Requested Information exempt from disclosure.

4. The Authority will rely upon the written statement from the Company in denying a RTKL request for the Requested Information unless the Authority determines that the Requested Information is clearly not protected from disclosures under the RTKL. In the event the Authority determines that the Requested Information is clearly not exempt from disclosure, the Company must provide the

Requested Information to the Authority within 5 days of receipt of written notification of the Authority's determination.

5. The Authority will reimburse the Company for any costs associated with complying with these provisions only to the extent allowed under the fee schedule established by the Office of Open Records or as otherwise provided by the RTKL if the fee schedule is inapplicable.

6. If the Company fails to provide the Requested Information as provided in paragraph No. 4. ("Company's Refusal") the party requesting the information may have the right to challenge that failure to disclose before the Pennsylvania Office of Open Records ("OOR") and potentially the courts. Company hereby understands and agrees that the Authority will not argue in favor of the Company's non-disclosure of the Requested Information and will inform the tribunal that it directed Company to produce such information.

7. In the event of administrative or legal proceedings, or both, related to Company's Refusal, the following will apply:

i. Company will defend the Authority, at its sole cost, before an agency or court as to any matter or claim related to Company's Refusal. Company will provide that defense through independent legal counsel agreed to in advance by the Authority, in its sole discretion.

ii. Company further agrees that it will indemnify and hold the Authority harmless for any damages, penalties, costs, detriment or harm that the Authority may incur as a result of the Company's failure to releases Requested Information, including any statutory damages or order to pay any party's attorney's fees.

8. As between the parties, the Company agrees to waive all rights or remedies that may be available to it as a result of the Authority's disclosure of Requested Information pursuant to the RTKL.

9. The Company's duties relating to the RTKL are continuing duties that survive the expiration or termination of this Agreement and shall continue as long as the Company has Requested Information in its possession.

B. Force Majeure. Neither contracting party will be liable for inadequate performance to the extent caused by a condition (for example, natural disaster, act of war or terrorism, riot, labor condition and governmental action) that was beyond the party's reasonable control.

C. No Third-Party Beneficiaries. There are no third-party beneficiaries to this Agreement.

D. Maintenance of Records. Regardless of the impact of the Right-to-Know Law, Company shall maintain all data, records, memoranda, statements of services rendered, correspondence and copies thereof, in adequate form, detail and arrangement, for the Authority's benefit for a minimum of three (3) years following the termination or expiration of this Agreement. Such information must be maintained in a secure and professionally reasonable manner. Thereafter, Company shall contact the Authority before disposing of any such materials and the Authority may direct that some or all of such materials be delivered to the Authority.

E. Assignment. This Agreement may not be transferred or assigned by Company without the prior written consent of the Authority which consent may be withheld in the sole discretion of the Authority, any transfer or assignment made without the prior written consent of the Authority shall be void.

F. Non-Discrimination. Company agrees to abide by all legal provisions regarding non-discrimination in hiring and contracting made applicable by federal, state and local laws.

G. Notices. Any legal notice or demand given by one party to the other under this Agreement shall be in writing and served by a delivery service, against written receipt or signed proof of delivery addressed to the other party at the address set forth above, unless a party shall have provided written notice to the other identifying a new address for notice. Notice to the Authority shall be labeled "c/o/ General Counsel". All notices shall be deemed given on the day after the notice was given to the courier or Postal service.

H. Captions. The captions in this Agreement are for convenience only and are not a part of this Agreement and do not in any way define, limit, describe or amplify the terms and provisions of this Agreement or the scope or intent thereof.

I. General Indemnity. Company shall be responsible for, and shall indemnify, defend, and hold harmless the Company and its Members, officers, employees, attorneys and agents (the "Indemnified Parties") from all claims, liabilities, damages, and costs including reasonable attorneys' fees, for bodily injury (including death and workers compensation claims) and damage to real or tangible personal property arising from or related to the negligence or other tortious acts, errors, and omissions of Company, its employees, or its subcontractors while engaged in performing the work of this Agreement or while present on the Authority's premises, and for breach of this Agreement regarding the use or nondisclosure of proprietary and confidential information where it is determined that Company is responsible for any use of such information not permitted by this Agreement. This indemnification obligation shall not be reduced in any way by any limitation on the amount or type of damages, compensation, or benefits payable by Company or its subcontractors under any employee benefit act including but not limited to Workers' Compensation Acts, Disability Benefits Acts, or other Employee Benefit Act.

J. Entire Agreement. This Agreement contains the entire agreement of the parties with respect to the matter covered by this Agreement. No other agreement, statement, representation, understanding or promise made by any party or by any employee, officer, or agent or any party, that is contained in this Agreement, shall be binding or valid. Any revisions, additions, and/or modifications of this Agreement must be set forth in writing and signed by all parties.

K. Exhibits and Interpretation. All Exhibits to this Agreement are hereby incorporated by reference as though set forth fully herein. The contracting parties acknowledge and agree that (i) each party reviewed and negotiated the terms and provisions of this Agreement and has contributed to it; and (ii) the rule of construction to the effect that any ambiguities are resolved against the drafting party shall not be employed in the interpretation of the Agreement, regardless of which party was generally responsible for the preparation of this Agreement.

L. Order of Precedence. In the event of an inconsistency between provisions of this Agreement, it shall be resolved by giving precedence in the following order: (1) the main body of this

Agreement (not including Exhibits); (2) the RFP (Exhibit "B"), (3) the Company's Proposal (Exhibit "C") and (4) all other exhibits. It is Company's responsibility to study this Agreement and to report at once in writing to the Authority any errors, inconsistencies, discrepancies, omissions or conflicts discovered between any provisions of the Agreement. Any work performed by the Company prior to receiving a written response from the Authority with respect to any alleged error, inconsistency, discrepancy, omission or conflict shall be at the Company's own risk and expense.

M. Specific Proposals. It is understood that the Authority shall have the absolute discretion to accept, reject or modify any proposal or offer which Company may bring to the Authority's attention during the term of this Agreement. The Authority may direct that Company suspend or modify any of its Services related to this Agreement at any time.

N. Independent Contractor. Company agrees that it, as well its employees, are independent contractors as to any Services provided and this Agreement is not intended to create any form of employment relationship.

O. Applicable Law and Venue. This Agreement shall be governed by and interpreted and enforced in accordance with the laws of the Commonwealth of Pennsylvania (without regard to any conflict of laws provisions) and the decisions of the Pennsylvania courts. The parties hereto irrevocably consent to the exclusive jurisdiction of the First Judicial District of Pennsylvania, being the Philadelphia Court of Common Pleas and waiving any claim or defense that such forum is not convenient or proper. Company agrees that the Philadelphia Court of Common Pleas shall have *in personam* jurisdiction over it, and consents to service of process in any manner authorized by Pennsylvania law.

P. Taxes.

1. Company hereby certifies that neither it, nor any of its parent or subsidiary entities, is delinquent or overdue in the payment of any tax or fee to the City or County of Philadelphia or the Commonwealth of Pennsylvania. Company also certifies that its Philadelphia Commercial Activity License No. is: _____. Company further certifies that its Federal Tax ID. No. is: _____.

2. As an agency of the Commonwealth of Pennsylvania, and a local government agency, the Authority is exempt from the payment of state and local sales and use and other taxes on material, equipment or other personal property. Company agrees that the fees, prices or rates stated in this Agreement (1) do not include any state or local taxes, surcharges or fees on the Authority in connection with this transaction, and (2) do include all other applicable taxes for which Company is liable. In the event Company's performance under this Agreement creates a tax liability, such taxes, including but not limited to, real estate taxes, school taxes, use & occupancy taxes, and sales taxes shall be the sole obligation of Company, and Company shall maintain current accounts as to the payment of such taxes and be liable over to the Authority for any taxes assesses against the Authority as a result of Company's performance under this Agreement.

Q. Ownership of Authority Materials. As between the parties, the Authority shall own and retain all right, title and interest in and to all Authority data, records, policies, statements, advertisements, programs, procedures, files, any and all Authority Provided Resources, such as, documents, or data provided by the Authority, including but not limited to the RFP, and all written

summaries, findings and reports, and proposed policies and procedures produced by Company pursuant to this Agreement.

R. Insurance. Company agrees to provide the Authority the appropriate certificates of insurance in accordance with the Insurance Requirements of the RFP.

S. Waiver. No term or provision hereof shall be deemed waived by the parties unless such waiver or consent shall be in writing signed by both parties. No breach shall be excused unless it is in writing signed by the non-breaching party.

T. Prior Agreement. This Agreement supersedes and replaces any and all previous agreements between the parties.

U. Recitals. The Recitals set forth at the beginning of this Agreement are deemed incorporated herein, and the parties hereto represent they are true, accurate and correct.

V. Separation Clause. If any provision of this Agreement, or the application of any provision to any person or circumstances, is held invalid or unenforceable, the remainder of this Agreement and the application of such provision(s) to other persons or circumstances shall remain valid and enforceable.

IN WITNESS WHEREOF, and intending to be legally bound pursuant to the Uniform Written Obligations Act, 33 P.S. 6, the parties have set their hands and seals on the date first above written.

The Philadelphia Parking Authority

Attest:_____

Print Name:_____

Print Title:_____

By:_____
Scott A. Petri
Executive Director

APPROVED AS TO FORM

By: _____
Office of General Counsel

Company name

Witness: _____

Print Name:_____

Print Title:_____

By: _____

Print Name: _____

Print Title:_____

EXHIBIT A
Philadelphia Parking Authority
CONTRACTOR INTEGRITY PROVISIONS

1. Definitions.

a. **Confidential Information** means information that is not public knowledge, or available to the public on request, disclosure of which would give an unfair, unethical, or illegal advantage to another desiring to contract with the Authority.

b. **Consent** means written permission signed by a duly authorized officer or employee of the Authority, provided that where the material facts have been disclosed, in writing, by prequalification, bid proposal, or contractual terms, the Authority shall be deemed to have consented by virtue of execution of this Contract.

c. **Contractor** means the individual or entity that has entered into this Contract with the Authority, including directors, officers, partners, managers, key employees, and owners of more than a 5% interest.

d. **Contractor Related Parties** means any affiliates of the Contractor and the Contractor's officers and directors.

e. **Financial interest** mean any financial interest in a legal entity engaged in business for profit which comprises more than 5% of the equity of the business or more than 5% of the assets of the economic interest in indebtedness

f. **Gift** means any conveyance of anything of value, including cash, a gratuity (tip), favor, entertainment (including tickets to sporting events), travel, food, drink, a loan, employment or services.

2. The Contractor shall maintain the highest standards of integrity in the performance of this Contract and shall take no action in violation of state or federal laws, regulations, or other requirements that govern contracting with the Authority, including these Contractor Integrity Provisions.

3. The Contractor shall not disclose to others any confidential information gained by virtue of this Contract.

4. Contractor, its affiliates, agents, employees and anyone in privity with Contractor shall not, in connection with this or any other agreement with the Authority, directly or indirectly, offer, confer, or agree to confer any pecuniary benefit or gift on anyone, for any reason, including as consideration for the decision, opinion, recommendation, vote, other exercise of discretion, or violation of a known legal duty by any officer or employee of the Authority.

5. Contractor confirms that no Authority officer or employee holds a financial interest in Contractor.

6. Contractor shall have no financial interest with or in any other contractor, subcontractor, or supplier providing services, labor, or material under this contract, unless the financial interest is disclosed to the Authority in writing and the Authority consents to Contractor's financial interest prior to the Authority's execution of the contract. Contractor shall disclose the financial interest to

the Authority at the time of bid or proposal submission, or if no bids or proposals are solicited, no later than Contractor's submission of the contract signed by Contractor.

7. When Contractor has reason to believe that any breach of ethical standards as set forth in law or these Contractor Integrity Provisions has occurred or may occur, including but not limited to contact by an Authority officer or employee which, if acted upon, would violate such ethical standards, Contractor shall immediately notify the Authority contracting officer or the Authority's Office General Counsel in writing.

8. Contractor, by submission of its bid or proposal and/or execution of this contract and by the submission of any bills, invoices or requests for payment pursuant to the contract, certifies and represents that it has not violated any of these Contractor Integrity Provisions in connection with the submission of the bid or proposal, during any contract negotiations or during the term of the contract, to include any extensions thereof.

9. Contractor agrees to reimburse the Authority for the reasonable costs of investigation incurred by the Authority's Office of General Counsel, or its designee, for investigations of the Contractor's compliance with the terms of this or any other agreement between the Contractor and the Authority that results in the suspension or debarment of the Contractor. Contractor shall not be responsible for investigative costs for investigations that do not result in the Contractor's suspension or debarment.

10. Contractor shall cooperate with the Authority's Office of General Counsel, or its designee, in its investigation of any alleged officer or employee breach of ethical standards and any alleged Contractor non-compliance with these Contractor Integrity Provisions. Contractor agrees to make identified Contractor employees available for interviews at reasonable times and places. Contractor, upon the inquiry or request of an investigator, shall provide, or if appropriate, make promptly available for inspection or copying, any information of any type or form deemed relevant by the Authority's designated investigator to Contractor's integrity and compliance with these provisions. Such information may include, but shall not be limited to, Contractor's business or financial records, documents or files of any type or form that refer to or concern this contract. Contractor shall incorporate this paragraph in any agreement, contract or subcontract it enters into in the course of the performance of this contract/agreement solely for the purpose of obtaining subcontractor compliance with this provision. The incorporation of this provision in a subcontract shall not create privity of contract between the Authority and any such subcontractor, and no third party beneficiaries shall be created thereby.

11. For violation of any of these Contractor Integrity Provisions the Authority may terminate this and any other contract with Contractor, claim liquidated damages in an amount equal to the value of anything received in breach of these Provisions, claim damages for all additional costs and expenses incurred in obtaining another contractor to complete performance under this contract, and debar and suspend Contractor from doing business with the Authority. These rights and remedies are cumulative, and the use or non-use of any one shall not preclude the use of all or any other. These rights and remedies are in addition to those the Commonwealth may have under law, statute, regulation, or otherwise.

12. Contractor certifies to the best of its knowledge and belief that within the last five (5) years Contractor or Contractor Related Parties have not:

a) been indicted or convicted of a crime involving moral turpitude or business honesty or integrity in any jurisdiction;
b) been suspended, debarred or otherwise disqualified from entering into any contract with any governmental agency;
c) had any business license or professional license suspended or revoked;
d) had any sanction or finding of fact imposed as a result of a judicial or administrative proceeding related to fraud, extortion, bribery, bid rigging, embezzlement, misrepresentation or anti-trust; and
e) been, and is not currently, the subject of a criminal investigation by any federal, state or local prosecuting or investigative agency and/or civil anti-trust investigation by any federal, state or local prosecuting or investigative agency.

If Contractor cannot so certify to the above, then it must submit along with its bid, proposal or contract a written explanation of why such certification cannot be made and the Authority will determine whether a contract may be entered into with the Contractor. The Contractor's obligation pursuant to this certification is ongoing from and after the effective date of the contract through the termination date thereof. Accordingly, the Contractor shall have an obligation to immediately notify the Authority in writing if at any time during the term of the contract if becomes aware of any event which would cause the Contractor's certification or explanation to change. Contractor acknowledges that the Authority may, in its sole discretion, terminate the contract for cause if it learns that any of the certifications made herein are currently false due to intervening factual circumstances or were false or should have been known to be false when entering into the contract.

Exhibit “B”
Request for Proposal

Exhibit “C”
Company’s Proposal

Appendix C

Insurance Requirements

THE PHILADELPHIA PARKING AUTHORITY
INSURANCE REQUIREMENTS – RFP No. 21-13
HEALTH INSURANCE BROKER SERVICES

Prior to commencement of the contract and until completion of your work **Vendor** shall, at its sole expense, maintain the following insurance on its own behalf, with an insurance company or companies having an A.M. Best Rating of "A-: Class VII" or better, and furnish to The Philadelphia Parking Authority (PPA) Certificates of Insurance evidencing same. Coverage must be written on an "occurrence" basis (exception – professional liability may be written on a "claims-made basis) and shall be maintained without interruption through the entire period of this agreement.

1. Workers Compensation and Employers Liability: in the State in which the work is to be performed and elsewhere as may be required and shall include, where applicable, U.S. Longshoremen's and Harbor Workers' Coverage.
    a) Workers' Compensation Coverage: Statutory Requirements
    b) Employers Liability Limits not less than:
        Bodily Injury by Accident: $500,000 Each Accident
        Bodily Injury by Disease: $500,000 Each Employee
        Bodily Injury by Disease: $500,000 Policy Limit

2. Commercial General Liability: including Premises-Operations, Independent Contractors, Products/Completed Operation, Broad Form Property Damage, Contractual Liability (including Liability for Employee Injury assumed under a Contract), and Personal Injury Coverage.
    a) Occurrence Form with the following limits:
        (1) General Aggregate: $2,000,000
        (2) Products/Completed Operations Aggregate: $1,000,000
        (3) Each Occurrence: $1,000,000
        (4) Personal and Advertising Injury: $1,000,000
        (5) Fire Damage (any one fire): $ 50,000
        (6) Medical Expense (any one person): $ 5,000
    b) General Aggregate must apply on a Per Location Basis as applicable.
    c) Owner must be named as additional insured as shown in requirement #8.

3. Automobile Liability: (Note: if no owned vehicles, show at least hired and non-owned coverage)
    a) Coverage to include:
        (1) All Owned, Hired and Non-Owned Vehicles
        (2) Contractual Liability Coverage (including Liability for Employee Injury assumed under a Contract)
    b) Per Accident Combined Single Limit: $1,000,000
    c) Owner must be named as additional insured as shown in requirement #8.

4. Excess/Umbrella Liability Insurance with a minimum acceptable limit of coverage of $5,000,000 per occurrence and aggregate. Such coverage shall be excess of the general liability insurance, business auto liability insurance, and employers liability as required by this contract. Owner must be named as additional insured as shown in requirement #8.

5. Professional (E&O) Liability Insurance with minimum acceptable limits of $1,000,000 per claim, $2,000,000 aggregate. Claims-made is acceptable.

6. Deductibles or Self-Insured Retention's: **Vendor** is responsible to pay any and all deductibles and/or self-

insured retentions that may apply to the required insurance.

7. Financial Rating of Insurance Companies:
   a) A.M. Best Rating: A – (Excellent) or Higher
   b) A.M. Best Financial Size Category: Class VII or Higher

8. The Philadelphia Parking Authority, The City of Philadelphia, The Commonwealth of Pennsylvania its agents, employees, representatives, officers and directors individually and collectively, shall be added as ADDITIONAL INSUREDS on the policies as noted above. **Vendor's** coverage shall be primary and non-contributory to any other coverage available to Philadelphia Parking Authority, including, without limitation, coverage maintained by Philadelphia Parking Authority wherein Philadelphia Parking Authority is named insured, and that no act of omission shall invalidate the coverage.

9. It is agreed that **Vendor's** insurance will not be cancelled, materially changed or non-renewed without at least thirty (30) days written notice to The Philadelphia Parking Authority, 701 Market Street, Suite 5400, Philadelphia, PA 19106, by Certified Mail-Return Receipt Requested.

10. Waiver of Rights of Recovery and Waiver of Rights of Subrogation:
    a) **Vendor** waives all rights of recovery against The Philadelphia Parking Authority and all additional Insureds for loss or damage covered by any of the insurance maintained by **Vendor** pursuant to this Contract.
    b) **Vendor** and its respective insurance carriers hereby waive all rights of subrogation against The Philadelphia Parking Authority and all additional insureds for loss or damage covered by any of the insurance maintained by **Vendor** Pursuant to this contract.
    c) If any of the policies of insurance required under this Contract require an endorsement to provide for the waiver of subrogation set forth in b, above, then the named insured's of such policies will cause them to be endorsed.

11. The amount of insurance provided in the aforementioned insurance coverages, shall not be construed to be a limitation of the liability on the part of the **Vendor**.

    None of the requirements contained herein as to the types, limits, or Philadelphia Parking Authority's approval of insurance coverage to be maintained by **Vendor** are intended to and shall not in any manner, limit, qualify, or quantify the liabilities and obligations assumed by **Vendor** under the Contract Documents, any other agreement with **Vendor**, or otherwise provided by law.

12. Any type of insurance or any increase in limits of liability not described above which the Authority requires for its own protection or on account of statue shall be its own responsibility and at its own expense.

13. The carrying of insurance shall in no way be interpreted as relieving **Vendor** of any responsibility or liability under the contract.

14. Prior to the commencement of work or use of premises, **Vendor** shall file Certificates of Insurance with The Philadelphia Parking Authority, which shall be subject to The Philadelphia Parking Authority's approval of adequacy of protection and the satisfactory character of the insurer. The Certificates of Insurance should be mailed within five days of receipt of these insurance requirements to The Philadelphia Parking Authority, 701 Market Street, Suite 5400, Philadelphia, PA 19106, regardless of

when your work will start. Project description and Job Number must be shown on the Certificate of Insurance.

In the event of a failure of **Vendor** to furnish and maintain said insurance and to furnish satisfactory evidence thereof, The Philadelphia Parking Authority shall have the right (but not the obligation) to take out and maintain the same for all parties on behalf of **Vendor** who agrees to furnish all necessary information thereof and to pay the cost thereof to The Philadelphia Parking Authority immediately upon presentation of an invoice.

15. Failure of **Vendor** to obtain and maintain the required insurance shall constitute a breach of contract and **Vendor** will be liable to the Philadelphia Parking Authority for any and all cost, liabilities, damages, and penalties (including attorney's fees, court, and settlement expenses) resulting from such breach, unless the Philadelphia Parking Authority provides **Vendor** with a written waiver of the specific insurance requirement.

16. None of the requirements contained herein as to the types, limits, or PPA's approval of insurance coverage to be maintained by **Vendor** are intended to and shall not in any manner, limit, qualify, or quantify the liabilities and obligations assumed by **Vendor** under the Contract Documents, any other agreement with the PPA, or otherwise provided by law.

17. If work involves subcontractors, **Vendor** shall require all subcontractors (of every tier) to meet the same insurance criteria as required of **Vendor**. The subcontractor's insurance must name the PPA as additional insured. **Vendor** shall maintain each subcontract's certificate of insurance on file and provide such information to the PPA for review upon request.

18. Failure of **Vendor** to provide insurance as herein required or failure of PPA to require evidence of insurance or to notify **Vendor** of any breach by **Vendor** of the requirements of this Section shall not be deemed to be a waiver of any of the terms of the Contract Documents, nor shall they be deemed to be a waiver of the obligation of **Vendor** to defend, indemnify, and hold harmless the indemnified parties as required herein. The obligation to procure and maintain any insurance required is a separate responsibility of **Vendor** and independent of the duty to furnish a copy or certificate of such insurance policies.

Appendix D

Plan Summaries

Keystone Health Plan East

HMO C1-F1

Phila Parking Authority

Keystone Health Plan East is a Health Maintenance Organization (HMO). This is a managed care program. Coverage is available when your care is provided or referred by a Keystone primary care physician (PCP). Your Keystone PCP may also refer you to other Keystone providers for care, if needed.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non-emergency or elective hospital admissions and procedures prior to the admission or procedure. Your participating provider will contact IBC for authorization. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefit limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	Coverage
Benefit Period	Calendar year*
Doctor's Office Visits	
Primary Care Services	$15 Copayment
Specialist Services	$30 Copayment
Preventive Care for Adults and Children	100%
Pediatric Immunizations	100% (office visit copayment does not apply)
Routine Eye Exam	$30 Copayment (once every two calendar years)
Routine Gynecological Exam/PAP *1 per calendar year for women of any age (No referral required)*	100%
Mammogram *(No referral required)*	100%
Nutrition Counseling For Weight Management *6 visits per calendar year*	100%
Outpatient Laboratory/Pathology	100%

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount resets to $0 at the start of the calendar year on January 1.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Independence

Benefits are administered by Keystone Health Plan East, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

www.ibx.com

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Benefit	Coverage
Maternity	
First OB Visit	$15 Copayment
Hospital	100%
Inpatient Hospital Services	
Facility	100%
Physician/Surgeon	100%
Inpatient Hospital Days	Unlimited
Outpatient Surgery	
Facility	100%
Physician/Surgeon	100%
Emergency Room	$150 Copayment (waived if admitted)
Urgent Care Center	$50 Copayment
Ambulance	
Emergency	100%
Non-Emergency	100%
Outpatient X-Ray/Radiology+	
Routine Radiology/Diagnostic	$30 Copayment
MRI/MRA, CT/CTA Scan, PET Scan	$30 Copayment
Therapy Services	
Physical and Occupational 30 total visits combined per calendar year	$30 Copayment
Cardiac Rehabilitation 36 visits per calendar year	$30 Copayment
Pulmonary Rehabilitation 36 visits per calendar year	$30 Copayment
Speech 20 visits per calendar year	$30 Copayment
Orthoptic/Pleoptic 8 sessions lifetime maximum	$30 Copayment
Spinal Manipulations *20 visits per calendar year*	$30 Copayment
Allergy Injections *(Copayment waived if no office visit is charged)*	100%
Injectable Medications	
Standard Injectables	100%**
Biotech/Specialty Injectables	100%
Chemo/Radiation/Dialysis	100%
Outpatient Private Duty Nursing *360 hours per calendar year*	100%
Skilled Nursing Facility *120 days per calendar year*	100%
Hospice and Home Health Care	100%
Durable Medical Equipment and Prosthetics	100%

** Office visits subject to copayment.

\+ Copayment not applicable when service is performed in Emergency Room or office setting.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	Coverage
Mental Health Care	
Outpatient	$30 Copayment
Inpatient	100%
Serious Mental Illness Care	
Outpatient	$30 Copayment
Inpatient	100%
Substance Abuse Treatment	
Outpatient/Partial Facility Visits	$30 Copayment
Rehabilitation	100%
Detoxification	100%
Out-of-Pocket Maximum[1]	
Individual	$1,000
Family	$2,000

1 The in-network out-of-pocket maximum includes copayments, coinsurance and deductible.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

What Is Not Covered?

- Services not medically necessary
- Service or supplies which are experimental or investigative except, when approved by Keystone Health Plan East, Routine Costs associated with Qualifying Clinical Trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Outpatient services that are not performed by your Primary Care Physician's Designated Provider
- Alternative Therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (TTY: 711).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Independence Phila Parking Authority

Coverage for: FAMILY| **Plan Type:** HMO

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, at www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). 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 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	For Referred Provider $1,000 person / $2,000 family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	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 you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copayment (copay)/visit	Not Covered	None
	Specialist visit	$30 copay/visit	Not Covered	PCP referral required.
	Preventive care/screening/immunization	No Charge	Not Covered	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)	$30 copay/test(X-Ray)/No Charge(Blood Work)	Not Covered	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	$30 copay/test	Not Covered	PCP referral required. Pre-certification required for certain services. *See section General Information.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.ibx.com/preapproval	Generic drugs	Not Covered	Not Covered	None
	Preferred brand	Not Covered	Not Covered	None
	Non-preferred drugs	Not Covered	Not Covered	None
	Specialty drugs	No Charge	Not Covered	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self administered specialty drugs follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	Not Covered	Pre-certification may be required. *See section General Information.
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need immediate medical attention	Emergency room care	$150 copay/visit	Covered at in-network level	None
	Emergency medical transportation	No Charge	Covered at in-network level	None
	Urgent care	$50 copay/visit	Not Covered	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)	No Charge	Not Covered	Pre-certification required.
	Physician/surgeon fees	Not Covered	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	Not Covered	Pre-certification required.
	Inpatient services	No Charge	Not Covered	Pre-certification required.

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		a Referred Provider	an Out Of Network Provider	
If you are pregnant	Office visits	$15 copay/visit	Not Covered	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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	Not Covered	Not Covered	None
	Childbirth/delivery facility services	No Charge	Not Covered	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Pre-certification required.
	Rehabilitation services	$30 copay/visit	Not Covered	PCP referral required. Physical/ Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period.
	Habilitation services	$30 copay/visit	Not Covered	PCP referral required. Physical/ Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period.
	Skilled nursing care	No Charge	Not Covered	Pre-certification required. 120 visits/ benefit period.
	Durable medical equipment	No Charge	Not Covered	Pre-certification required for selected items. *See section General Information.
	Hospice services	No Charge	Not Covered	Pre-certification required.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit	Not Covered	Once every two calendar years.
	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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

- Bariatric Surgery
- Chiropractic Care
- Routine Eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY:711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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: Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

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

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	$30
Hospital (facility) copayment	$0
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	**$30**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$2,600**
The total Peg would pay is	**$2,600**

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	$30
Hospital (facility) copayment	$0
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	**$200**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$4,300**
The total Joe would pay is	**$4,500**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$0
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	**$200**
Coinsurance	**$0**
What isn't covered	
Limits or exclusions	**$100**
The total Mia would pay is	**$300**

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: 1-800-ASK-BLUE (TTY:711)

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: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ 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 1-800-275-2583.

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: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 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: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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*.

Personal Choice

PC C1-F1-O2

Phila Parking Authority

Personal Choice® our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing care through Personal Choice's large network of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With Personal Choice...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network[1]
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE		
Individual	$0	$1,500
Family	$0	$4,500
OUT-OF-POCKET MAXIMUM**		
Individual	$1,000	$10,000
Family	$2,000	$30,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 Copayment	50%, after deductible
Specialist Services	$30 Copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	50%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[3]	100%	50%, NO deductible
MAMMOGRAM	100%	50%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[3]	100%	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible

1 Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional 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 Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

3 Combined in/out-of-network

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each calendar year on January 1.

** The in-network out-of-pocket maximum includes copayments, coinsurance and deductible. The out-of-network out-of-pocket maximum includes coinsurance only.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Independence

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Benefit	In-Network	Out-of-Network[1]
MATERNITY		
First OB visit	$15 Copayment	50%, after deductible
Hospital	100%	50%, after deductible[4]
INPATIENT HOSPITAL SERVICES		
Facility	100%	50%, after deductible[4]
Physician/Surgeon	100%	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[4]
OUTPATIENT SURGERY		
Facility	100%	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	$150 Copayment (Copayment waived if admitted)	$150 Copayment (Copayment waived if admitted); no deductible
URGENT CARE CENTER	$50 Copayment	50%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-emergency	100%	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY *(Copayment not applicable when service performed in ER or office setting)*		
Routine Radiology/Diagnostic	$30 Copayment	50%, after deductible
MRI/MRA, CT/CTA, PET Scan	$30 Copayment	50%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[3]	$30 Copayment	50%, after deductible
Cardiac Rehabilitation 36 visits per year[3]	$30 Copayment	50%, after deductible
Pulmonary Rehabilitation 36 visits per year[3]	$30 Copayment	50%, after deductible
Speech 20 visits per year[3]	$30 Copayment	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum[3]	$30 Copayment	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year*[3]	$30 Copayment	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%, after deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%[2]	50%, after deductible
Biotech/Specialty Injectables	$50 Copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*[3]	90%	50%, after deductible
SKILLED NURSING FACILITY *120 days per year*[3]	100%	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	50%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$30 Copayment	50%, after deductible
Inpatient	100%	50%, after deductible[4]

1 Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional 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 Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

2 Office visit subject to copayment

3 Combined in/out-of-network

4 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, maternity, mental health, serious mental illness, substance abuse and detoxification services.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	In-Network	Out-of-Network[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 Copayment	50%, after deductible
Inpatient	100%	50%, after deductible[4]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$30 Copayment	50%, after deductible
Rehabilitation	100%	50%, after deductible[4]
Detoxification	100%	50%, after deductible[4]

1 Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional 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 Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

4 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, maternity, mental health, serious mental illness, substance abuse and detoxification services.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Alternative Therapies/complementary medicine
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy and hippotherapy
- Treatment of obesity, except for surgical treatment of morbid obesity and weight loss programs provided through Healthy Lifestyles
- Treatment of sexual dysfunction not related to organic disease except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care

This summary represents only a partial listing of the benefits and exclusions of the Personal Choice Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call 1-800-626-8144 (outside Philadelphia) or 215-557-7577 (if calling within the Philadelphia area).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Independence Phila Parking Authority

Coverage for: 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, at www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). 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 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-network Provider $0 person / $0 family; for Out-of-network Provider $1,500 person / $4,500 family.	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?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	For In-network Provider $1,000 person / $2,000 family; for Out-of-network Provider $10,000 person / $30,000 family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	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 you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copayment (copay)/visit	50%	None
	Specialist visit	$30 copay/visit	50%	None
	Preventive care/screening/immunization	No Charge	50%, 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)	$30 copay/test(X-Ray)/No Charge(Blood Work)	50%	None
	Imaging (CT/PET scans, MRIs)	$30 copay/test	50%	Pre-certification required for certain services. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.ibx.com/preapproval	Generic drugs	Not Covered	Not Covered	None
	Preferred brand	Not Covered	Not Covered	None
	Non-preferred drugs	Not Covered	Not Covered	None
	Specialty drugs	$50 Copay/prescription fill	50%	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self administered specialty drugs follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	50%	Pre-certification may be required. *See section General Information.20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fees	No Charge	50%	Pre-certification may be required. *See section General Information.20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need immediate medical attention	Emergency room care	$150 copay/visit	Covered at in-network level	None
	Emergency medical transportation	No Charge	Covered at in-network level	None
	Urgent care	$50 copay/visit	50%	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.

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Physician/surgeon fees	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Inpatient services	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
If you are pregnant	Office visits	$15 copay/visit	50%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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 facility services	No Charge	50%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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.
If you need help recovering or have other special health needs	Home health care	No Charge	50%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network or BlueCard services.
	Rehabilitation services	$30 copay/visit	50%	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 and out-of-network.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
	Habilitation services	$30 copay/visit	50%	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 and out-of-network.
	Skilled nursing care	No Charge	50%	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 and out-of-network.
	Durable medical equipment	30%	50%	Pre-certification required for selected items. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network or Bluecard services.
	Hospice services	No Charge	50%	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
- Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com
- 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
- Private-duty nursing
- Routine Eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY:711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

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: Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

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

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	$30
Hospital (facility) copayment	$0
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	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$80**

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	$30
Hospital (facility) copayment	$0
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	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,000**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$0
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	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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: 1-800-ASK-BLUE (TTY:711)

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: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ 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 1-800-275-2583.

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: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 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: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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*.

Keystone Direct POS

C1-F1-O1

Keystone HEALTH PLAN EAST
DIRECT POS

Phila Parking Authority

Keystone Direct POS lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. Under this plan, you must select a Primary Care Physician, but can access most care in-network or out-of-network without a referral. Referrals are required for routine radiology/diagnostic, spinal manipulation and physical/occupational therapy. You maximize your benefits when you access care from a Keystone participating provider. If you access care from a provider who does not participate in our network higher out-of-pocket costs apply.

To get the most out of your benefits program, below are some key terms that you will need to understand.

- **Referral** - Documentation from your PCP authorizing care at a participating specialist for covered services.
- **Preapproval/Precertification** - Approval from Independence Blue Cross (IBC) for non emergency or elective hospital admissions and procedures prior to the admission or procedure. For in-network (referred) services, your participating provider will contact IBC for authorization. For out-of-network (self-referred) services, you are responsible for obtaining approval for certain services. For more information on the services requiring precertification, please refer to the back page of this summary.
- **Designated site** - PCPs are required to choose one radiology, physical therapy, occupational therapy, and laboratory provider where they will send all their Keystone members. You can view the sites selected by your PCP at www.ibx.com.

Your Member Handbook will provide additional details about your benefits program. It will include information about exclusions and benefits limitations. It is important to note that this program may not cover all your health care services. Services may not be covered because they are not included under your benefits contract, not medically necessary, or limited by a benefit maximum (e.g., visit limit). After reviewing this information, please contact our Customer Service department if you have additional questions.

Benefit	In-Network	Out-of-Network*
BENEFIT PERIOD	Calendar Year[5]	Calendar Year[5]
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,500
OUT-OF-POCKET MAXIMUM[6]		
Individual	$1,000	$3,000
Family	$2,000	$9,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary Care Services	$15 Copayment[1]	70%, after deductible
Specialist Services	$30 Copayment	70%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

1 Must go to the Primary Care Physician chosen by the member.

5 A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each calendar year on January 1.

6 The in-network out-of-pocket maximum includes copayments, coinsurance and deductible. The out-of-network out-of-pocket maximum includes coinsurance only.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

The benefits may be changed by IBC to comply with the applicable federal/state laws and regulations.

Independence

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Benefit	In-Network	Out-of-Network*
To receive the highest level of benefit, you must receive the following services from your Primary Care Physician's designated sites. You can view your Primary Care Physician's designated sites at www.ibx.com.		
OUTPATIENT X-RAY/RADIOLOGY[***]		
Routine Radiology/Diagnostic	$30 Copayment[2]	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$30 Copayment	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY[4]	100%	70%, after deductible
PHYSICAL AND OCCUPATIONAL THERAPIES *30 total visits per year for PT/OT combined*	$30 Copayment[2]	70%, after deductible
To receive the highest level of benefits, you can see any Keystone Health Plan East participating provider for the following services.		
SPINAL MANIPULATIONS *20 visits per year*	$30 Copayment[2]	70%, after deductible
THERAPY SERVICES		
Cardiac Rehabilitation 36 visits per year	$30 Copayment	70%, after deductible
Pulmonary Rehabilitation 36 visits per year	$30 Copayment	70%, after deductible
Speech 20 visits per year	$30 Copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum	$30 Copayment	70%, after deductible
INPATIENT HOSPITAL SERVICES		
Facility	100%	70%, after deductible[3]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[3]
OUTPATIENT SURGERY		
Facility	100%	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$150 Copayment (waived if admitted)	$150 Copayment (waived if admitted), NO deductible
URGENT CARE CENTER	$50 Copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, NO deductible
Non-Emergency	100%	70%, after deductible
MATERNITY		
First OB Visit	$15 Copayment	70%, after deductible
Hospital	100%	70%, after deductible[3]
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*	100%	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*	100%	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%[1]	70%, NO deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, NO deductible
ROUTINE EYE EXAM	$30 Copayment (once every two years)	Not Covered
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%[**]	70%, after deductible
Biotech/Specialty Injectables	$50 Copayment	70%, after deductible

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

** Office visits subject to copayment.

*** Copayment not applicable when service performed in Emergency Room or office setting.

1 Must go to the Primary Care Physician chosen by the member.

2 Referral required from Primary Care Physician.

3 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, maternity, mental health, serious mental illness, substance abuse and detoxification services.

4 Lab requisition form required from an in-network provider.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

The benefits may be changed by IBC to comply with the applicable federal/state laws and regulations.

Benefit	In-Network	Out-of-Network*
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*	90%	70%, after deductible
SKILLED NURSING FACILITY	100% 120 days per year	70%, after deductible 60 days per year
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	70%	50%, after deductible
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$30 Copayment	70%, after deductible
Inpatient	100%	70%, after deductible[3]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 Copayment	70%, after deductible
Inpatient	100%	70%, after deductible[3]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial Facility Visits	$30 Copayment	70%, after deductible
Inpatient Rehabilitation	100%	70%, after deductible[3]
Detoxification	100%	70%, after deductible[3]

* Out-of-Network providers may bill you the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. This amount may be significant.

3 Inpatient hospital day limit combined for all self-referred inpatient medical, maternity, maternity, mental health, serious mental illness, substance abuse and detoxification services.

To receive maximum benefits, services must be provided by a Keystone participating provider. This is a highlight of benefits available. The benefits and exclusions for In-Network and Out-of-Network Care are not the same. All benefits are provided in accordance with the HMO group contract and Out-of-Network benefit booklet/certificate.

The benefits may be changed by IBC to comply with the applicable federal/state laws and regulations.

What Is Not Covered?

- Services not medically necessary
- Service or supplies which are experimental or investigative, except routine costs associated with qualifying clinical trials and when approved by Keystone Health Plan East
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- Reversal of voluntary sterilization
- Expenses related to organ donation for non-member recipients
- Acupuncture
- Dental care, including dental implants, and non-surgical treatment of temporomandibular joint syndrome (TMJ)
- Music therapy, equestrian therapy, and hippotherapy
- Treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction resulting from an injury
- Routine foot care, unless medically necessary or associated with the treatment of diabetes
- Foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes
- Cranial prostheses including wigs intended to replace hair
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Alternative Therapies/complementary medicine
- Self-injectable drugs

This summary represents only a partial listing of benefits and exclusions of the Keystone Direct POS program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all of your health care expenses. Read your HMO group contract/member handbook and Out-of-Network group health benefits booklet/certificate carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (TTY: 711).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

Independence Phila Parking Authority

Coverage for: FAMILY | **Plan Type:** POS

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, at www.ibx.com/LGBooklet or by calling 1-800-ASK-BLUE (TTY:711). 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 1-800-ASK-BLUE (TTY:711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-network Provider $0 person / $0 family; for Out-of-network Provider $500 person / $1,500 family.	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?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
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?	For In-network Provider $1,000 person / $2,000 family; for Out-of-network Provider $3,000 person / $9,000 family.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, 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. See www.ibx.com/find_a_provider or call 1-800-ASK-BLUE (TTY:711) for a list of network providers.	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 you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 Copayment (copay)/visit	30%	None
	Specialist visit	$30 copay/visit	30%	PCP referral required for spinal manipulations, routine x-rays, and physical/occupational therapy.
	Preventive care/screening/immunization	No Charge	30%, 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)	$30 copay/test(X-Ray)/No Charge(Blood Work)	30%	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	$30 copay/test	30%	PCP referral required. Pre-certification required for certain services. *See "General Information" section. 20% reduction in benefits for failure to pre-cert out-of-network.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.ibx.com/preapproval	Generic drugs	Not Covered	Not Covered	None
	Preferred brand	Not Covered	Not Covered	None
	Non-preferred drugs	Not Covered	Not Covered	None
	Specialty drugs	$50 copay/prescription fill	30%	This cost share amount is for specialty injectable or infusion therapy drugs covered by the medical benefit. These drugs are typically administered by a health care professional in an office or outpatient facility. Self administered specialty drugs follow the applicable retail prescription cost-share under the FutureScripts Specialty Pharmacy Program. Prior-authorization required. *See section Outpatient Services.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30%	Pre-certification may be required. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network.
	Physician/surgeon fees	No Charge	30%	Pre-certification may be required. *See section General Information. 20% reduction in benefits for failure to pre-cert out-of-network.
If you need immediate medical attention	Emergency room care	$150 copay/visit	Covered at in-network level	None
	Emergency medical transportation	No Charge	Covered at in-network level	None
	Urgent care	$50 copay/visit	30%	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	Facility fee (e.g., hospital room)	No Charge	30%	Precertification required. 20% reduction in benefits

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
				for failure to pre-cert out-of-network.
stay	Physician/surgeon fees	No Charge	30%	Precertification required. 20% reduction in benefits for failure to pre-cert out-of-network.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/visit	30%	Precertification required. 20% reduction in benefits for failure to pre-cert out-of-network.
	Inpatient services	No Charge	30%	Precertification required. 20% reduction in benefits for failure to pre-cert out-of-network.
If you are pregnant	Office visits	$15 copay/visit	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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 facility services	No Charge	30%	Office visit cost share applies to the first OB visit only. Depending on the type of services, a 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.
If you need help recovering or have other special health needs	Home health care	No Charge	30%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network.
	Rehabilitation services	$30 copay/visit	30%	PCP referral required for Physical/Occupational Therapies. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. Separate visit limits for in and out-of-network care.
	Habilitation services	$30 copay/visit	30%	PCP referral required for Physical/Occupational Therapies. Physical/Occupational Therapies: 30 visits combined/ benefit period. Speech Therapy: 20 visits/ benefit period. Separate visit limits for in and out-of-network care.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		an In-Network Provider	an Out-Of Network Provider	
	Skilled nursing care	No Charge	30%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network. 120 visits/ benefit period. Separate visit limits for in and out-of-network care.
	Durable medical equipment	30%	50%	Pre-certification required for selected items. *See section General Information. 20% reduction in benefits for failure to precert out-of-network.
	Hospice services	No Charge	30%	Pre-certification required. 20% reduction in benefits for failure to pre-cert out-of-network.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit	Not Covered	Once every two calendar years.
	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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Routine Eye care (adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. To contact the plan at 1-800-ASK-BLUE (TTY:711) or the contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, you should contact your State Insurance regulator regarding possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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: Pennsylvania Insurance Department - 1-877-881-6388 - http://www.insurance.pa.gov/Consumers.

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.

***For more information about limitations and exceptions, see plan or policy document at www.ibx.com/LGBooklet**

Does this plan meet 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 see examples of how this plan might cover costs for a sample medical situation, see the next section.

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	$30
Hospital (facility) copayment	$0
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	$30
Coinsurance	$0
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	**$80**

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	$30
Hospital (facility) copayment	$0
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	$200
Coinsurance	$500
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,000**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist copayment	$30
Hospital (facility) copayment	$0
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	$200
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$200**

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: 1-800-ASK-BLUE (TTY:711)

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: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ 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 1-800-275-2583.

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: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 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: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

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*.

Select Drug Program

$5/$25/$40

Independence

Philadelphia Parking Auth

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program® is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Benefit Period	Calendar Year**
Retail Pharmacy - Member Cost Sharing (Participating Pharmacy)	
Generic Formulary	$5 Copayment
Brand Formulary	$25 Copayment
Non-Formulary Brand	$40 Copayment
Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy) *Available for maintenance drugs*	
Generic Formulary	$5 Copayment (1-30 days supply); $5 copayment (31-90 days supply)
Brand Formulary	$25 Copayment (1-30 days supply); $25 copayment (31-90 day supply)
Non-Formulary Brand	$40 Copayment (1-30 days supply); $40 Copayment(31-90 days supply)
Total Out-of-Pocket Maximum	Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan.
Out-of-Network Reimbursement	0%; your prescription drug program does not include coverage for drugs purchased at out-of-network pharmacies

**A calendar year benefit period begins on January 1 and ends on December 31.

02/18 - PA - 51+ PC Select RX Rider $5/$25/$40 w/ Orals OOPM 2017
10014073

Benefit	Coverage
Network	FutureScripts® network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 30 days supply
Retail for maintenance drugs	Up to 90 days supply
Mail order for maintenance drugs	Up to 90 days supply
Formulary	IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**.
Specialty Pharmacy Program *Mandatory for Self-Administered Specialty Drugs*	All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply.
Covered Prescription Drugs[1]	Compound medications of which at least one ingredient is a prescription drug Retin-A through age 35 Contraceptives Prescribed smoking cessation drugs Self-injectable drugs Insulin Insulin needles and syringes Lancets (no copayment required at participating pharmacies) Glucometers (no copayment required at participating pharmacies) Diabetic supplies (i.e test strips)

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Experimental drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)

DELTA DENTAL PPO℠: YOUR SMILE IS COVERED

GO PPO!
You can visit any licensed dentist under this plan, but you'll maximize plan value by selecting a Delta Dental PPO[1] dentist. PPO network dentists have agreed to reduced contracted rates and can't "balance bill" you for additional fees.[2] Find a dentist at **deltadentalins.com**.[3]

CONVENIENT ONLINE SERVICES: DELTADENTALINS.COM
- Create a free Online Services account from your PC or smartphone to view benefits, eligibility and claims status or check average dental costs in your area.
- Update your dental benefit statement delivery preference: Go paperless!
- Find a Delta Dental PPO dentist near you.

NO ID CARD NECESSARY
Just provide your dental office with your name, birth date and enrollee ID or social security number. Register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.

HASSLE-FREE TRANSITION & EASY BENEFITS COORDINATION
New to Delta Dental PPO? This plan covers treatment started and completed after your plan's effective date of coverage.[4] If you're covered under two plans, ask your dentist to include information about both plans with your claim, and we'll handle the rest.

SAVE WITH A PPO DENTIST

DELTA DENTAL PPO

NON-DELTA DENTAL DENTISTS

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] Enrollees are responsible for any coinsurance, deductible, amount over the plan maximum and charges for non-covered services.

[3] Verify that your dentist is a contracted Delta Dental PPO network dentist before each appointment.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier will be responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

HL_PPO_2 col #78011

DELTA DENTAL®

WE KEEP YOU SMILING®

Plan Benefit Highlights for: Philadelphia Parking Authority

Group No: 15761

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes same-sex domestic partner only) and eligible dependent children to the end of the month that dependent turns age 19 or age 26if dependent is full-time student			
Deductibles	None			
Deductibles waived for Diagnostic & Preventive (D & P)?	N/A			
Maximums	Delta Dental PPO dentists: $2,000 per person each calendar year Non-Delta Dental PPO dentists: $1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	**Delta Dental PPO dentists****	**Non-Delta Dental PPO dentists****
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings	90 %	80 %
Endodontics (root canals) Covered Under Basic Services	90 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	90 %	80 %
Oral Surgery Covered Under Basic Services	90 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	60 %	50 %
Prosthodontics Bridges, dentures and implants	60 %	50 %
Orthodontic Benefits Dependent children to age 19	50 %	50 %
Orthodontic Maximums	$ 1,500 Lifetime	$ 1,500 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental of Pennsylvania
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

SCHEDULE OF VISION BENEFITS

	PARTICIPATING PROVIDER	NON-PARTICIPATING PROVIDER
Routine Exam (for glasses) Once every 12 months	Covered 100%	Reimbursement Amt. Up to $ 40
Lenses Once every 12 months Single Vision Bifocal Blended Bifocals Progressive Trifocal Lenticular Polycarbonate (under age 19) 1 Year Scratch Protection Photochromic Solid or Gradient Tints	Standard Glass or Plastic Covered 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%	 Up to $ 40 Up to $ 50 Up to $ 50 Up to $ 75 Up to $ 75 Up to $100 N/A N/A N/A N/A
Frame Once every 24 months	Covered 100% if within the plan's wholesale allowance	Up to $ 50
Or: Contact Lenses Once every 12 months Elective Contact Lenses Medically Necessary (requires prior authorization from **VBA**)	In lieu of all other materials/services* Up to $150 UCR (usual, customary, reasonable)	In lieu of all other materials/services* Up to $150 Up to $300
Lasik Surgery (once every 8 years)	N/A	Up to $250

***** The contact allowance is applied to all services/materials associated with contact lenses. This includes, but is not limited to, all exam costs including the routine eye exam, contact exam, fitting, dispensing, or contact lenses. There is no guarantee that the contact allowance will cover the entire cost.

NOTE: Utilization of both participating and non-participating providers in the same benefit period may reduce or eliminate coverage for services and materials depending upon reimbursement or provider payment amounts. Contact **VBA**'s member services department for more information.

Philadelphia Parking Authority – VBA # 2148

VBA maintains a network of more than 18,000 participating optometrists, ophthalmologists and retail locations nationwide to provide professional vision care for those covered under this plan.

HOW YOUR VISION PROGRAM WORKS

Select a **VBA** participating provider in your area. When scheduling an appointment, please notify the **VBA** participating provider that your vision coverage is administered by **VBA**. A list of participating providers is available on our website at vbaplans.com. The provider selected will contact **VBA** to verify eligibility via online system and will process services received electronically.

To verify your benefit eligibility prior to visiting your eye care provider, please visit our website at vbaplans.com or contact one of **VBA**'s exceptional customer care representatives toll-free at 1-800-432-4966.

Eligibility (from the last date of service)

Exam: Once every 12 months
Lenses: Once every 12 months
Frames: Once every 24 months

Or:

Contact Lenses (in lieu of all other benefits for the benefit period)
Once every 12 months

Member Services
To verify eligibility/dependent age, locate a participating provider or to receive answers to all your vision care related inquiries, please contact one of our exceptional customer care representatives at 1-800-432-4966/option 5.

PARTICIPATING PROVIDER COVERAGE

Vision Examination
A complete analysis of the eyes and related structures to determine the presence of any vision problems.

Spectacle Lenses
Your program provides the finest quality lenses fabricated to **VBA**'s exacting standards. A **VBA** participating provider will order the proper lenses and verify their accuracy when finished.

Frames
VBA plans offer a wide selection of fully covered designer frames; however, if you choose a frame which costs more than the amount allowed by your plan, you will be responsible for any additional controlled charges.

Or:

Contacts Selected in Lieu of Glasses
When contact lenses are selected in lieu of glasses, your plan will provide a total allowance of up to **$150.00**. This includes, but is not limited to, all exam costs including the routine eye exam, contact exam, fitting, dispensing or contact lenses. There is no guarantee that the contact allowance will cover the entire cost. This is in lieu of all other benefits for the benefit period. You will not receive any additional monies for contact lenses and/or contact lens exam costs that are more than the **$150.00** allowance.

Medically Necessary Contact Lenses
Contact lenses are fully covered on a UCR (usual, customary, reasonable as determined by **VBA**) basis when a **VBA** participating provider receives prior approval for one of the following services related to eye disease or injury: visual acuity problems not correctable with spectacle lenses, anisometropia of 4 diopters or greater, and keratoconus.

Lasik
All **VBA** covered subscribers are eligible to receive a significant discount at TLC or QualSight locations nationwide. For more information regarding this benefit, please visit our website or call one of **VBA**'s exceptional customer care representatives at 1-800-432-4966/option 5. However, the patient will be required to pay the provider in full and submit a reimbursement form to **VBA**. The Plan will reimburse the patient up to a maximum of **$250.00**, once every eight (8) years.

Plan Allowances
When you choose to obtain services from a **VBA** participating provider, this plan covers the benefits described herein (examination, professional services, lenses and frames) at no expense to you, if the materials selected fall within your plan's allowance. **NOTE: Through a VBA Participating Provider only, Progressive Lenses, Photochromic, Solid or Gradient Tints and 1 Year Scratch Protection are covered in full.**

Exclusions/Limitations
There are no benefits for professional services or materials connected with vision training / subnormal vision aids / non-prescription lenses / lost or broken lenses or frames / medical or surgical treatment of the eyes / two pairs of glasses in lieu of bifocals / services or materials provided as a result of any Workers' Compensation Law or similar legislation or any eye exam required by an employer as a condition of employment.

Optional Vision Materials at a Controlled Price
This plan is designed to fully cover your visual needs rather than cosmetic lens and frame options. There will be extra controlled costs involved if you select any of the following: rimless frames / a frame costing more than your plan's allowance / polycarbonate lens material for adults (covered if under 19) / elective contact lenses (in excess of your plan's allowance) / coated lenses (except 1 year scratch protection is covered through a **VBA** participating provider only).

NON-PARTICIPATING PROVIDERS

If you choose to see a non-participating provider, make an appointment and pay the provider their full fee. Obtain an itemized receipt which must contain the following information: patient's name, date services began, services and/or materials received, and type of lenses (single vision, bifocal, etc.). There is no assurance the non-participating reimbursement schedule will cover the entire cost of the examination, glasses, or contacts.

Mail your receipts along with a **VBA** out-of-network reimbursement form (which can be printed online at vbaplans.com) to:

VBA
400 Lydia Street, Suite 300
Carnegie, PA 15106

GROUP BENEFITS

GROUP RETIREE INSURANCE PLAN
SUMMARY OF COVERAGE

PLAN FOR RETIREES OF:
PHILADELPHIA PARKING AUTHORITY
THROUGH BENISTAR EMPLOYER SERVICES TRUST (BEST)

UNDERWRITTEN BY: HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

PART A SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
HOSPITALIZATION [2] Semi-private room and board, general nursing, and miscellaneous services and supplies:			
First 60 days	All but $1,364	100% of Medicare Part A Deductible	**$0**
61st through 90th day	All but $341 per day	100% of Medicare Part A Coinsurance	**$0**
91st through 150th day (60 day Lifetime Reserve Period)	All but $682 per day	100% of Medicare Part A Coinsurance	**$0**
Once Lifetime Reserve days are used (or would have ended if used) additional 365 days of confinement per person per lifetime	$0	100%	**$0**
SKILLED NURSING FACILITY CARE Semi-private room and board, skilled nursing and rehabilitative services and other services and supplies. You must meet Medicare's requirement which includes hospitalization of at least 3 days. You must enter a Medicare-approved facility within 30 days after leaving the hospital:			
First 20 days	All approved amounts	$0	**$0**
21st through 100th day	All but $170.50 per day	Up to 100% of Medicare SNF Coinsurance	**$0**
101st through 365 day	$0	$0	**All other charges**

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
BLOOD DEDUCTIBLE – **Hospital Confinement and Out-Patient Medical Expenses** When furnished by a hospital or skilled nursing facility during a covered stay.			
First 3 pints Additional amounts	$0 100%	100% $0	**$0** **$0**
HOSPICE CARE – **Hospital Confinement and Out-Patient Medical Expenses** Pain relief, symptom management and support services for terminally ill.			
As long as Physician certifies the need	All costs, but limited to costs for out-patient drug and in-patient respite care	Co-insurance charges for in-patient respite care, drugs and biologicals approved by Medicare	**All other charges**

PART B SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
OUT-PATIENT MEDICAL EXPENSES **The Policy may cover the following Medicare Part B Benefits:** • *Physician Services Benefit* • *Specialist Services Benefit* • *Outpatient Hospital Services and Ambulatory Surgical Care Benefit* • *Outpatient Diagnostic and Radiology Services Benefit* • *Outpatient Mental Health and Substance Abuse Services Benefit* • *Outpatient Rehabilitative and Cardiac Rehabilitative Services Benefit* • *Emergency Care Benefit* • *Urgent Care Benefit* • *Ambulance Services Benefit* • *Durable Medical Equipment and Prosthetics Benefit* *All Medicare Part B Benefits are based on per vist, except Ambulance Services Benefit, which is based on per trip, and Durable Medical Equipment and Prosthetics Benefit, which is based on per device.*			
Medicare Part B Deductible First $185 of Medicare-approved amounts	$0	100% of Medicare Part B Deductible	**$0**
Remainder of Medicare-approved amounts	80%	100% of the remaining Medicare Part B Coinsurance	**$0**

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
Part B Excess Charges for Non-Participating Medicare providers covers the difference between the 115% Medicare limiting fee and the Medicare-approved Part B charge	$0	100%	**$0**

ADDITIONAL SERVICES

SERVICES	MEDICARE PAYS[1]	PLAN PAYS[1]	YOU PAY
PREVENTIVE MEDICAL CARE & CANCER SCREENINGS[3] Coverage for expenses incurred by a covered person for physical exams, preventive screening tests and services, cancer screenings, and any other tests or preventive measures determined to be appropriate by the attending Physician. Refer to your Medicare and You handbook for more information on Preventive services.			
"Welcome to Medicare" Physical Exam -within first 12 months of Part B enrollment	100%	$0	**$0**
Annual Wellness Visit	100%	$0	**$0**
Vaccinations	100%	$0	**$0**
Preventive Care Cancer Screening Benefits[3]	Generally 100% for most preventive screenings. Some screenings subject to the Medicare Part B Deductible and Coinsurance	100% of remaining covered expenses Incurred not covered by Medicare	**$0**
FOREIGN TRAVEL EMERGENCY Medically necessary emergency care services.			
Emergency services needed due to Injury or Sickness of sudden and unexpected onset during the first 60 days while traveling outside the United States.	$0	80% after !$250 Deductible (to a lifetime maximum of $50,000)	!**$250 Deductible and then 20% of expenses incurred** (to a lifetime maximum of $50,000, then 100% thereafter)

[1] Coverage amounts are valid from the policy effective date to December 31, 2019. This chart describes coverage that is only available to persons who are at least 65 and Medicare-eligible. Medicare amounts typically change January 1 of each year.

[2] A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row. Hospital does not include any institution or part thereof that is used primarily as a nursing home, convalescent home, or Skilled Nursing Facility; a place for rest, custodial, educational or rehabilitory care; a place for the aged; or, a place for alcoholism or drug addiction.

[3] If any of the cancer screening tests are not covered by Medicare, the plan will pay the usual and customary charges incurred. Please refer to your certificate for a full description of preventive screenings.

Please note this policy also may cover certain benefits mandated by the state where the employer is sitused or the state where you reside. Refer to your certificate for a description of any additional benefits.

Limitations & Exclusions: The Hartford's Insurance Plan does not cover any expense that is not a Medicare Eligible Expense or beyond the limits imposed by Medicare for such expenses or excluded by name or specific description by Medicare, except as specifically provided in the policy. The plan does not cover: Any part of a covered expense to the extent paid by Medicare; benefits payable under one benefit of the policy to the extent covered under another benefit of the policy; or expense incurred after coverage terminates, except as stated in the Extension-of-Benefits provision of the policy.