

# Medical Benefit Highlights - Option 3

PPO \$1,500/\$20-\$40/100% - AES

Covered Services		Your Costs (You pay)	
Benefits per Contract Year		In-Network	Out-of-Network
Deductible (Embedded) <sup>1</sup> Individual/Family		\$1,500/\$3,000	\$5,000/\$10,000
Out-of-Pocket Maximum (Embedded) <sup>2</sup> Individual/Family		\$7,900/\$15,800	\$10,000/\$20,000
Coinsurance		0%	50%
Preventive Services		In-Network	Out-of-Network
Preventive Care		No charge no deductible	50% no deductible
Preventive Colonoscopy			
Preventive Plus Providers		No charge no deductible	Not covered
Hospital Based		\$750 no deductible	50% no deductible
Physician Services		In-Network	Out-of-Network
Primary Care Physician (PCP)			
Office Visit		\$20 no deductible	50% after deductible
Telemedicine Visit		\$15 no deductible	50% after deductible
Specialist			
Office Visit		\$40 no deductible	50% after deductible
Telemedicine Visit		\$30 no deductible	50% after deductible
Retail Health Clinic Visit		\$20 no deductible	50% after deductible
Urgent Care Visit		\$85 no deductible	50% after deductible
Virtual Care <sup>3</sup>		In-Network	Out-of-Network
Telemedicine		No charge no deductible	Not covered
Teledermatology		No charge no deductible	Not covered
Telebehavioral Health		No charge no deductible	Not covered
Therapy Services		In-Network	Out-of-Network
Physical Therapy (30 visits/year) <sup>4</sup>			
Freestanding		\$40 no deductible	50% after deductible
Hospital Based		\$40 no deductible	50% after deductible
Occupational Therapy (30 visits/year) <sup>4</sup>			
Freestanding		\$40 no deductible	50% after deductible
Hospital Based		\$40 no deductible	50% after deductible
Speech Therapy (20 visits/year) <sup>5</sup>		\$40 no deductible	50% after deductible

### Emergency Services

Emergency Room (copay not waived if admitted)

Emergency Ambulance

Non-Emergency Ambulance

### In-Network

\$400 no deductible

No charge after deductible

No charge after deductible

### Out-of-Network

Covered at In-Network level

Covered at In-Network level

50% after deductible

### Hospital Services

Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)<sup>6</sup>

Observation Services (copay waived if admitted)

Maternity Hospital Services<sup>6</sup>

Inpatient Professional Services (includes Maternity)

### In-Network

No charge after deductible

\$400 no deductible

No charge after deductible

No charge after deductible

### Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

### Outpatient Surgery

Freestanding

Hospital Based

Outpatient Professional Services

### In-Network

\$250 after deductible

\$250 after deductible

No charge after deductible

### Out-of-Network

50% after deductible

50% after deductible

50% after deductible

### Outpatient Diagnostics

Diagnostic Medical (EKG)

Routine Radiology (X-Ray)

Freestanding

Hospital Based

Advanced Imaging (MRI/MRA, CT/CTA Scan, PET Scan)

Freestanding

Hospital Based

### In-Network

\$40 no deductible

\$40 no deductible

\$40 no deductible

\$80 no deductible

\$80 no deductible

### Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

### Outpatient Lab and Pathology

Freestanding

Hospital Based

### In-Network

\$40 no deductible

\$80 no deductible

### Out-of-Network

50% after deductible

50% after deductible

### Other Medical Services

Spinal Manipulations (20 visits/year)<sup>5</sup>

Acupuncture (18 visits/year)<sup>5</sup>

Standard Injectables

Allergy Injections

Biotech/Specialty Injectables

Home/Office

Outpatient

Chemotherapy

### In-Network

\$40 no deductible

\$40 no deductible

No charge no deductible

No charge no deductible

\$100 no deductible

\$200 no deductible

No charge after deductible

### Out-of-Network

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

50% after deductible

Dialysis	No charge after deductible	50% after deductible
Skilled Nursing Facility (120 days/year) <sup>5</sup>	No charge after deductible	50% after deductible
Home Health (60 visits/year) <sup>5</sup>	No charge after deductible	50% after deductible
Hospice	No charge after deductible	50% after deductible
Durable Medical Equipment (DME)	No charge after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	\$40 no deductible	50% after deductible
All Other Services	\$40 no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse) <sup>6</sup>	No charge after deductible	50% after deductible

- 1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.
- 2 Embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum.
- 3 Telemedicine is provided by a designated telemedicine provider, please visit [www.ibx.com/findcarenow](http://www.ibx.com/findcarenow).
- 4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit in and out-of-network.
- 5 Combined in and out-of-network.
- 6 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

This summary represents only a partial listing of benefits and exclusions of the Medical 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 benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.ibx.com/LGBooklet](http://www.ibx.com/LGBooklet) or call 1-800-ASK-BLUE (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

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.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. [www.ibx.com](http://www.ibx.com)