Independence

Medical Benefit Highlights - Option 1

PPO $4,000/$30-$60/90% - AES

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$4,000/$8,000	$6,000/$12,000
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$7,900/$15,800	$12,000/$24,000
Coinsurance	10%	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	$30 no deductible	50% after deductible
Telemedicine Visit	$20 no deductible	50% after deductible
Specialist		
Office Visit	$60 no deductible	50% after deductible
Telemedicine Visit	$40 no deductible	50% after deductible
Retail Health Clinic Visit	$30 no deductible	50% after deductible
Urgent Care Visit	$100 no deductible	50% after deductible
Virtual Care[3]	**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)[4]		
Freestanding	$60 no deductible	50% after deductible
Hospital Based	$60 no deductible	50% after deductible
Occupational Therapy (30 visits/year)[4]		
Freestanding	$60 no deductible	50% after deductible
Hospital Based	$60 no deductible	50% after deductible
Speech Therapy (20 visits/year)[5]	$60 no deductible	50% after deductible

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Emergency Services	In-Network	Out-of-Network
Emergency Room (copay not waived if admitted)	$400 no deductible	Covered at In-Network level
Emergency Ambulance	10% after deductible	Covered at In-Network level
Non-Emergency Ambulance	10% after deductible	50% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6]	10% after deductible	50% after deductible
Observation Services	$400 no deductible	50% after deductible
Maternity Hospital Services[6]	10% after deductible	50% after deductible
Inpatient Professional Services (includes Maternity)	10% after deductible	50% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	$300 after deductible	50% after deductible
Hospital Based	$300 after deductible	50% after deductible
Outpatient Professional Services	10% after deductible	50% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	$60 no deductible	50% after deductible
Routine Radiology (X-Ray)		
Freestanding	$60 no deductible	50% after deductible
Hospital Based	$60 no deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$200 no deductible	50% after deductible
Hospital Based	$200 no deductible	50% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	$60 no deductible	50% after deductible
Hospital Based	$120 no deductible	50% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year)[5]	$60 no deductible	50% after deductible
Acupuncture (18 visits/year)[5]	$60 no deductible	50% after deductible
Standard Injectables	No charge no deductible	50% after deductible
Allergy Injections	No charge no deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	$150 no deductible	50% after deductible
Outpatient	$300 no deductible	50% after deductible
Chemotherapy	10% after deductible	50% after deductible

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Dialysis	10% after deductible	50% after deductible
Skilled Nursing Facility (120 days/year)[5]	10% after deductible	50% after deductible
Home Health (60 visits/year)[5]	10% after deductible	50% after deductible
Hospice	10% after deductible	50% after deductible
Durable Medical Equipment (DME)	10% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$60 no deductible	50% after deductible
All Other Services	$60 no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	10% 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.

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 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