Independence

Medical Benefit Highlights

The Preferred Provider Organization Tier 1 - Devereux

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1]		
Individual / EE+Child / Family (EE/SP/DP, EE+Children, Family)	$420/$630/$840	Not covered
Out-of-Pocket Maximum (Embedded)[2]		
Individual / EE+Child / Family (EE/SP/DP, EE+Children, Family)	$1,735/$2,575/$3,465	Not covered
Coinsurance	15%	Not covered
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	Not covered
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$25 no deductible	Not covered
Telemedicine Visit	$25 no deductible	Not covered
Specialist		
Office Visit	$50 no deductible	Not covered
Telemedicine Visit	$50 no deductible	Not covered
Retail Health Clinic Visit	$25 no deductible	Not covered
Urgent Care Visit	$50 no deductible	Not covered
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 (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Occupational Therapy (60 visits/year)[4]		
Freestanding	$40 no deductible	Not covered
Hospital Based	$40 no deductible	Not covered
Speech Therapy (60 visits/year)[4]	$40 no deductible	Not covered
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$300 no deductible	Covered at In-Network level
Emergency Ambulance	15% after deductible	Covered at In-Network level
Non-Emergency Ambulance	15% after deductible	Not covered
Hospital Services	**In-Network**	**Out-of-Network**
Inpatient Hospital Services	$250/Admission after deductible,	Not covered

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	then 15%	
Observation Services	15% after deductible	Not covered
Maternity Hospital Services	$250/Admission after deductible, then 15%	Not covered
Inpatient Professional Services (includes Maternity)	15% after deductible	Not covered

Outpatient Surgery	**In-Network**	**Out-of-Network**
Freestanding	15% after deductible	Not covered
Hospital Based	15% after deductible	Not covered
Outpatient Professional Services	15% after deductible	Not covered

Outpatient Diagnostics	**In-Network**	**Out-of-Network**
Diagnostic Medical (EKG)	15% after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	15% after deductible	Not covered
Hospital Based	15% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$100 after deductible, then 15%	Not covered
Hospital Based	$100 after deductible, then 15%	Not covered

Outpatient Lab and Pathology	**In-Network**	**Out-of-Network**
Freestanding	No charge no deductible	Not covered
Hospital Based	No charge no deductible	Not covered

Other Medical Services	**In-Network**	**Out-of-Network**
Spinal Manipulations (15 visits/year)	$40 no deductible	Not covered
Acupuncture (18 visits/year)	$50 no deductible	Not covered
Standard Injectables	15% after deductible	Not covered
Allergy Injections	15% after deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	15% after deductible	Not covered
Outpatient	15% after deductible	Not covered
Chemotherapy	15% after deductible	Not covered
Dialysis	15% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	15% after deductible	Not covered
Home Health	15% after deductible	Not covered
Hospice	15% after deductible	Not covered
Durable Medical Equipment (DME)	No charge after deductible	Not covered
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$20 no deductible	50% after deductible
All Other Services	$20 no deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)	No charge after deductible	50% after deductible

1 Embedded deductible: Each covered member will not be required to satisfy any more than the EE only deductible value. If you are enrolled in a Tier other than EE only, the combination of enrolled members will meet the deductible value together, in any combination.

2 Embedded out-of-pocket maximum – Each covered member will not be required to satisfy any more than the EE only out-of-pocket value. If you are enrolled in a Tier other than EE only, the combination of enrolled members will meet the out-of-pocket value together, in any combination.

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3 Telemedicine is provided by a designated telemedicine provider, please visit **www.ibx.com/findcarenow**.

4 Physical Therapy, Occupational Therapy, Speech Therapy, and Cognitive Therapy combined visit limit.

The EPO Program provides in-network-only benefits through the Personal Choice® or BlueCard® PPO networks. Except for emergency services, all care must be received from participating Personal Choice network or BlueCard PPO network providers. There is no benefit coverage for care received from non-preferred, non-participating providers.

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**

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Drug Benefit Highlights

Freestanding Premium 15%/35%50%

Covered Services	Your Costs (You pay)	
Benefits per Calendar Year	**In-Network**	**Out-of-Network**
Deductible	$0/$0	Not covered
Out-of-Pocket Maximum (Embedded)[1] Individual/EE+Child/Family	$4,000/$6,000	Not covered
Formulary[2]	Premium	
Dispense as Written (DAW) Provision[3]	Mandatory Generic	
Retail Pharmacy	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits[4]	90 day supply max	Not covered
Mail Order Pharmacy Available for maintenance drugs	**In-Network**	**Out-of-Network**
Tier 1 Generic Drugs	15%	Not covered
Tier 2 Preferred Brand Drugs	35%	Not covered
Tier 3 Non-Preferred Drugs	50%	Not covered
Dispensing Limits	100 day supply max	Not covered
Mandatory Mail for Maintenance Drugs[5]	Yes	Not covered
Drug Coverage	**In-Network**	**Out-of-Network**
ACA Preventive Drugs[6]	Covered	Not covered
Compound Medications	Covered	Not covered
Contraceptives	Covered	Not covered
Diabetic Supplies (i.e., test strips)	Covered	Not covered
Glucometers (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Insulin	Covered	Not covered
Insulin Needles and Syringes	Covered	Not covered
Lancets (no copayment/coinsurance required at participating pharmacies)	Covered	Not covered
Prescribed Tobacco Cessation Drugs (RX and OTC)	Covered	Not covered
Allergy Serum	Covered	Not covered
Blood, Blood Plasma	Not covered	Not covered
Drugs used for Cosmetic Purposes	Not covered	Not covered
Injectable Fertility Drugs	Not covered	Not covered
Investigational/Experimental Drugs	Not covered	Not covered
Non-Federal Legend Drugs	Not covered	Not covered
Over-The-Counter Drugs (Non-Prescription)	Not covered	Not covered
Weight Control Drugs	Not covered	Not covered

1 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, prior to receiving plan benefits.

2 Benefits will be provided for Covered Drugs and medicines appearing on the Drug Formulary. To check the formulary status of a drug or view a copy of the most recent formulary, log onto www.ibx.com.

3 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and you will be responsible for the member

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cost sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If you purchase a brand drug, you will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate member cost sharing for a brand drug.

4 CVS90 Saver Plus - 90-day supply of drugs to treat chronic conditions must be obtained at CVS or mail for same cost share, except first two fills may be 30-day fills obtained at any participating retail pharmacy.

5 All covered medications for chronic conditions (such as blood pressure medications) will be provided through our convenient mail order service, which allows you to order up to a 100-day supply. This benefit can save you time and money. If your doctor wants you to start the drug immediately, your 2 fill supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through our convenient mail order service. Member cost sharing is indicated above.

6 Certain designated preventative medications will not be subject to any cost-sharing or deductibles, but will be subject to the terms and conditions of your benefits contract. Refer to your summary of benefits, member handbook, and/or benefit booklet to determine if your plan includes 100 percent coverage for in-network preventive services.

This summary represents only a partial listing of benefits and exclusions of the Prescription Drug 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 pharmacy policy. As a result, this program 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).

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 are not covered. Devices or supplies except those specifically listed under covered drugs are not covered.

All covered self-administered specialty medications 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.

The pharmacy network includes more than 65,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the Find a Participating Pharmacy feature.

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Vision Benefit Highlights

Vision Care 130: 12/12/12

Covered Services (Calendar Year)	Your Costs (You pay)	
Exam	**In-Network**	**Out-of-Network**
Routine Eye Exam at Davis Participating Providers (1 exam/year)[1]	No charge	$40 Reimbursement
Retinal Imaging	$39	Not covered
Lenses (1 pair/year)[1]	**In-Network**	**Out-of-Network[2]**
Single Vision Lenses	No charge	$40 Reimbursement
Bifocal Lenses	No charge	$60 Reimbursement
Trifocal Lenses	No charge	$80 Reimbursement
Lenticular Lenses	No charge	$100 Reimbursement
Lens Options	**In-Network**	**Out-of-Network**
Progressive Lenses - Standard/Premium/Ultra/Ultimate	$50/$90/$140/$175	$60 Reimbursement
Polycarbonate Lenses - Single/Multifocal[3]	$30	Not covered
Digital/Intermediate Lenses	$30	Not covered
Photochromic Lenses - Single/Multifocal	No charge	Not covered
Photosensitive Lenses - Single/Multifocal	$65	Not covered
High-Index 1.67 / High-Index 1.74 Lenses	$55/$120	Not covered
Blue Light Lenses	$15	Not covered
Polarized Lenses	$75	Not covered
Lens Coatings		
Tinted Plastic Lenses	No charge	Not covered
UV-Coated Lenses	No charge	Not covered
Scratch-Resistant Coating - Single/Multifocal	No charge	Not covered
Scratch-Protection Plan - Single/Multifocal	$20/$40	Not covered
Anti-Reflective Coating - Standard/Premium/Ultra/Ultimate	$35/$48/$60/$85	Not covered
Frames (1 pair/year)[1]	**In-Network**	**Out-of-Network**
Collection Fashion Frames	No charge	Not covered
Collection Designer Frames	No charge	Not covered
Collection Premier Frames	$25	Not covered
Non-Collection Frames	Up to $130 Allowance (plus a 20% discount on overage)[4]	$50 Reimbursement
Visionworks Frames Option	Up to $180 Allowance (plus a 20% discount on overage)[4]	Not covered
Contact Lenses (in lieu of glasses) (1 pair/year)[1]	**In-Network**	**Out-of-Network**
Collection Contact Lenses Evaluation, Fitting & Follow-Up Care	No charge	Not covered
Collection Contact Lenses	Disposable Boxes/Multipacks: 4 per year Planned Replacement Boxes/Multipacks: 2 per year	Not covered
Non-Collection Standard Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to $60 Allowance	Not covered

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Non-Collection Specialty & Disposable Contact Lenses Evaluation, Fitting & Follow-Up Care	Up to $60 Allowance	Not covered
Non-Collection Contact Lenses	Up to $130 Allowance[4]	$105 Reimbursement
Medically-Necessary Contact Lenses[5]	No charge	$225 Reimbursement

1 Combined in and out-of-network.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

4 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

5 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations 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.

Administered by Davis Vision.

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