

Medical Benefit Highlights

The Preferred Provider Organization Tier 3 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)	\$840/\$1,260/\$1,680	Not covered
Out-of-Pocket Maximum (Embedded) ² Individual / EE+Child / Family (EE/SP/DP, EE+Children, Family)	\$5,200/\$7,800/\$10,400	Not covered
Coinsurance	25%	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 Care³	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	25% after deductible	Covered at In-Network level
Non-Emergency Ambulance	25% after deductible	Not covered
Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services	\$250/Admission after deductible,	Not covered

Observation Services	then 25%	
Maternity Hospital Services	25% after deductible	Not covered
Inpatient Professional Services (includes Maternity)	\$250/Admission after deductible, then 25%	Not covered
	25% after deductible	Not covered
Outpatient Surgery	In-Network	Out-of-Network
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Outpatient Professional Services	25% after deductible	Not covered
Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	25% after deductible	Not covered
Routine Radiology (X-Ray)		
Freestanding	25% after deductible	Not covered
Hospital Based	25% after deductible	Not covered
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	\$100 after deductible, then 25%	Not covered
Hospital Based	\$100 after deductible, then 25%	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	25% after deductible	Not covered
Allergy Injections	25% after deductible	Not covered
Biotech/Specialty Injectables		
Home/Office	25% after deductible	Not covered
Outpatient	25% after deductible	Not covered
Chemotherapy	25% after deductible	Not covered
Dialysis	25% after deductible	Not covered
Skilled Nursing Facility (120 days/year)	25% after deductible	Not covered
Home Health	25% after deductible	Not covered
Hospice	25% 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.

- 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.
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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