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.

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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**