Independence

PAISBOA
HEALTH BENEFIT TRUST

Medical Benefit Highlights

HBT HD $2,500/$5,000

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Aggregate)[1]		
Individual/Family	$2,500/$5,000	$5,000/$10,000
Out-of-Pocket Maximum (See Footnote)[2]		
Individual/Family	$6,350/$12,700	$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	No charge no deductible	50% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP) Office Visit	No charge after deductible	50% after deductible
Specialist Office Visit	No charge after deductible	50% after deductible
Retail Health Clinic Visit	No charge after deductible	50% after deductible
Urgent Care Visit	No charge after deductible	50% after deductible
Virtual Care	**In-Network**	**Out-of-Network**
Telemedicine[3]	Covered	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]		
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible
Occupational Therapy (60 visits/year)[4]		
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible
Speech Therapy (60 visits/year)[5]	No charge after deductible	50% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room	No charge after deductible	Covered at In-Network level
Emergency Ambulance	No charge after deductible	Covered at In-Network level
Non-Emergency Ambulance	No charge 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]	No charge after deductible	50% after deductible
Maternity Hospital Services[6]	No charge after deductible	50% after deductible
Inpatient Professional Services (includes Maternity)	No charge after deductible	50% after deductible
Outpatient Surgery	**In-Network**	**Out-of-Network**

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Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible
Outpatient Professional Services	No charge after deductible	50% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG) [7]	No charge after deductible	50% after deductible
Routine Radiology (X-Ray) [7]		
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge after deductible	50% after deductible
Hospital Based	No charge after deductible	50% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year)[5]	No charge after deductible	50% after deductible
Acupuncture (18 visits/year)[5]	No charge after deductible	50% after deductible
Standard Injectables	No charge after deductible	50% after deductible
Allergy Injections	No charge after deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	No charge after deductible	50% after deductible
Outpatient	No charge after deductible	50% after deductible
Chemotherapy	No charge after deductible	50% after deductible
Dialysis	No charge after deductible	50% after deductible
Skilled Nursing Facility (120 days/year)[5]	No charge after deductible	50% after deductible
Home Health	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)	No charge after deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	No charge after deductible	50% after deductible

1 Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.

2 In-Network 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. Out-of-Network aggregate out-of-pocket maximum: For family coverage, the entire family out-of-pocket maximum must be met before copayments or coinsurance are applied for an individual member.

3 Telemedicine services are provided through Doctor on Demand. Please refer to Doctor on Demand materials for additional information about coverage and member cost sharing.

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.

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7 Office visit may be subject to copay.

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, please call the phone number listed on the back of your identification card, or log into your member portal account at **www.ibxpress.com**

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.

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