



## 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) <sup>1</sup> 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	
orgeni Care visit	No charge after deductible	50% after deductible	
Virtual Care	In-Network	Out-of-Network	
Telemedicine <sup>3</sup>	Covered	Not covered	
Therapy Services	In-Network	Out-of-Network	
Physical Therapy (60 visits/year) <sup>4</sup>	III WOW	- Out of Network	
Freestanding	No charge after deductible	50% after deductible	
Hospital Based	No charge after deductible	50% after deductible	
Occupational Therapy (60 visits/year) <sup>4</sup>	No charge after deductible	50% after deductible	
	No shares ofter deductible	EOO/ often deductible	
Freestanding	No charge after deductible	50% after deductible	
Hospital Based	No charge after deductible	50% after deductible	
Speech Therapy (60 visits/year) <sup>5</sup>	No charge after deductible	50% after deductible	
Emergency Services	In-Network	Out-of-Network	
Emergency Room	No charge after deductible	Covered at In-Network leve	
Emergency Ambulance	No charge after deductible	Covered at In-Network leve	
Non-Emergency Ambulance	No charge after deductible	50% after deductible	
Hospital Services	In-Network	Out-of-Network	
Inpatient Hospital Services (In-Network:	No charge after deductible	50% after deductible	
365 days/year; Out-of-Network: 70 days/year) <sup>6</sup>	, to sharge until deductible	55% and adductible	
Maternity Hospital Services <sup>6</sup>	No charge after deductible	50% after deductible	
Inpatient Professional Services (includes Maternity)	No charge after deductible	50% after deductible	
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Outpatient Surgery	In-Network	Out-of-Network	





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) <sup>7</sup>			
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) <sup>5</sup>	No charge after deductible	50% after deductible	
Acupuncture (18 visits/year) <sup>5</sup>	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) <sup>5</sup>	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) <sup>6</sup>	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
- 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.





## 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 <a href="https://www.ibxpress.com">www.ibxpress.com</a>

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 <a href="http://www.ibx.com/preapproval">http://www.ibx.com/preapproval</a> 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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