Independence

Medical Benefit Highlights

CCP Keystone Point-of-Service POS 5C

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**Referred**	**Self-Referred**
Deductible (Embedded)[1]		
Individual/Individual and Dependents/Family	$500/$1,000/$1,500	$500/$1,000/$1,500
Out-of-Pocket Maximum (Embedded)[2]		
Individual/Family	$4,500/$9,000	Not Applicable/Not Applicable
Coinsurance	0%	20%
Coinsurance Limit		
Individual/Family	Not Applicable/Not Applicable	$2,000/$6,000
Annual Copayment Maximum	$650	Not Applicable
Preventive Services	**Referred**	**Self-Referred**
Preventive Care	No charge no deductible	20% no deductible
Preventive Colonoscopy		
Hospital Based	No charge no deductible	20% no deductible
Physician Services	**Referred**	**Self-Referred**
Primary Care Physician (PCP) Office Visit	$10 no deductible	20% after deductible
Specialist Office Visit	$25 no deductible	20% after deductible
Retail Health Clinic Visit	$10 no deductible	20% after deductible
Urgent Care Visit	$24 no deductible	20% after deductible
Therapy Services	**Referred**	**Self-Referred**
Physical Therapy (Up to 60 consecutive days per condition covered, subject to significant improvement)[3]		
Freestanding	No charge no deductible	20% after deductible
Hospital Based	No charge no deductible	20% after deductible
Occupational Therapy (Up to 60 consecutive days per condition covered, subject to significant improvement)[3]		
Freestanding	No charge no deductible	20% after deductible
Hospital Based	No charge no deductible	20% after deductible
Speech Therapy (Up to 60 consecutive days per condition covered, subject to significant improvement)[3]	No charge no deductible	20% after deductible
Emergency Services	**Referred**	**Self-Referred**
Emergency Room (copay waived if admitted)	$35 no deductible	Covered at In-Network level
Emergency Ambulance	No charge no deductible	Covered at In-Network level
Non-Emergency Ambulance	No charge after deductible	20% after deductible
Hospital Services	**Referred**	**Self-Referred**
Inpatient Hospital Services (Referred: 365 days/year; Self-Referred: 120 days/year)[4]	No charge after deductible	20% after deductible
Maternity Hospital Services[4]	No charge after deductible	20% after deductible
Inpatient Professional Services (includes	No charge after deductible	20% after deductible

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Maternity)		
Outpatient Surgery	**Referred**	**Self-Referred**
Freestanding	No charge after deductible	20% after deductible
Hospital Based	No charge after deductible	20% after deductible
Outpatient Professional Services	No charge after deductible	20% after deductible
Outpatient Diagnostics	**Referred**	**Self-Referred**
Diagnostic Medical (EKG)	No charge no deductible	20% after deductible
Routine Radiology (X-Ray)		
Freestanding	No charge no deductible	20% after deductible
Hospital Based	No charge no deductible	20% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	No charge no deductible	20% after deductible
Hospital Based	No charge no deductible	20% after deductible
Outpatient Lab and Pathology	**Referred**	**Self-Referred**
Freestanding	No charge no deductible	20% after deductible
Hospital Based	No charge no deductible	20% after deductible
Other Medical Services	**Referred**	**Self-Referred**
Spinal Manipulations (Up to 60 consecutive days per condition covered, subject to significant improvement)	No charge no deductible	20% after deductible
Standard Injectables	No charge after deductible	20% after deductible
Allergy Injections	No charge no deductible	20% after deductible
Biotech/Specialty Injectables	No charge after deductible	20% after deductible
Chemotherapy	No charge after deductible	20% after deductible
Dialysis	No charge after deductible	20% after deductible
Skilled Nursing Facility (Referred: 180 days/year; Self-Referred: 240 days/year)	No charge after deductible	20% after deductible
Home Health	No charge after deductible	20% after deductible
Hospice	No charge after deductible	20% after deductible
Durable Medical Equipment (DME)	No charge after deductible	20% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)	$25 no deductible	20% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[4]	No charge after deductible	20% after deductible
Routine Eye Care	$25 no deductible	Not covered

[1] Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

[2] 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.

[3] Physical Therapy, Occupational Therapy, and Speech Therapy combined visit limit.

[4] Inpatient hospital out of network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

Keystone Point-of-Service lets you maintain freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by having care provided or referred by your primary care physician (PCP). You have the freedom to self-refer your care either to a Keystone participating provider or to providers who do not participate in our network; however, higher out-of-pocket costs apply. This program may not cover all your health care services.

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.

Referred benefits are underwritten or administered by Keystone Health Plan East; Self-Referred benefits are underwritten by QCC Insurance company, subsidiaries of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Vision Benefit Highlights

$35 Eyewear Benefit

Covered Services	Your Costs (You pay)	
Benefits	**In-Network[1]**	**Out-of-Network**
Annual Plan Maximum	Unlimited	
Deductible (Individual/Family)	$0/$0	$0/$0
Out-of-Pocket Maximum (Individual/Family)	$0/$0	$0/$0
Exam	**In-Network[1]**	**Out-of-Network**
Benefit Frequency		
Routine Eye Exam at Davis Participating Providers	Not covered	Not covered
Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 Every 24 Months	1 Every 24 Months
Single Vision Lenses	No charge	Subject to Reimbursement
Bifocal Lenses	No charge	Subject to Reimbursement
Trifocal Lenses	No charge	Subject to Reimbursement
Lenticular Lenses	No charge	Subject to Reimbursement
Lens Options[3]		
Standard Progressive Lenses	$50	Not covered
Premium Progressive Lenses	$90	Not covered
Ultra Progressive Lenses	$140	Not covered
Polycarbonate Lenses – Single Vision[4]	$30	Not applicable
Polycarbonate Lenses – Multifocal Vision[4]	$30	Not applicable
Photosensitive Lenses – Single Vision	$60	Not applicable
Photosensitive Lenses – Multifocal Vision	$70	Not applicable
High-Index Lenses	$55	Not applicable
Polarized Lenses	$60	Not applicable
Lens Coatings		
Tinted Plastic Lenses	$11	Not applicable
UV-Coated Lenses	$12	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	$15	Not applicable
Scratch-Resistant Coating Multifocal Lenses	$25	Not applicable
Scratch-Protection Plan Single Vision Lenses	Not covered	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	Not covered	Not applicable
Anti-Reflective Standard Lenses	$33	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable

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Frames	In-Network[1]	Out-of-Network
Benefit Frequency	1 Every 24 Months	1 Every 24 Months
Davis Collection Fashion Frames	No charge	Not applicable
Davis Collection Designer Frames	$16	Not applicable
Davis Collection Premier Frames	$35	Not applicable
Non-Davis Collection Frames	Up to $10 Allowance (plus a 20% discount on any overage)[5]	Subject to Reimbursement
Visionworks Frames Option	Up to $10 Allowance (plus a 20% discount on any overage) at Visionworks locations nationwide[5]	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	Not covered	Not covered
Davis Collection Standard Daily Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	Not covered	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	Not covered	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $35 Allowance; Evaluation: Not covered; (plus a 15% discount on any overage)[5]	Subject to Reimbursement
Medically-Necessary Contact Lenses[6]	No charge	Not covered

[1] Participating Davis provider benefit.

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

[3] Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

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

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

[6] 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.