

Gold health plans	Personal Choice® PPO Gold ²	
Benefits per calendar year ¹	You pay in-network	You pay out-of-network ⁴
Ded, individual/family	\$0/\$0	\$6,000/\$12,000
Coinsurance	20% unless otherwise noted	50% unless otherwise noted
Out-of-pocket maximum, individual/family includes: ¹¹	\$7,000/\$14,000 copay and coinsurance	\$12,000/\$24,000 ded and coinsurance
Preventive services ⁵		
Preventive care for adults and children	\$0	50% no ded
Preventive colonoscopy for colorectal cancer screening — Preventive Plus providers	\$0	n/a
Preventive colonoscopy for colorectal cancer screening — Hospital-based	\$750	50% no ded
Physician services		
Primary care office visit/retail clinic	\$30	50% after ded
Specialist office visit	\$65	50% after ded
Telemedicine ²⁸	\$20	Not covered
Urgent care	\$100	50% after ded
Spinal manipulations (20 visits per year) ⁶	\$50	50% after ded
Physical/occupational therapy (30 visits per year) Freestanding/Hospital-based ⁶	\$65/\$95	50% after ded/50% after ded
Hospital/other medical services		
Inpatient hospital services (includes maternity)	\$750 per day ⁷	50% after ded
Inpatient professional services (includes maternity)	20%	50% after ded
Emergency room (not waived if admitted)	\$350	\$350 no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	\$60/\$90	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	\$120/\$160	50% after ded/50% after ded
Biotech/specialty injectables — Home, office/outpatient	\$120/\$240	50% after ded/50% after ded
Infusion — Home, office/outpatient	\$65/\$130	50% after ded/50% after ded
Durable medical equipment/prosthetics	50%	50% after ded
Mental health, serious mental illness & substance abuse — outpatient	\$65	50% after ded
Mental health, serious mental illness & substance abuse — inpatient	\$750 per day ⁷	50% after ded
Outpatient surgery		
Ambulatory surgical facility	25% up to \$300 max	50% after ded
Hospital-based	25% up to \$700 max	50% after ded
Outpatient lab/pathology		
Freestanding	\$0	50% after ded
Hospital-based	50%	50% after ded
Prescription drugs ^{14,15,†}		
Rx ded (individual/family)	None	None
Retail generic	\$15 ^{16,19}	70%
Retail preferred brand	40% up to \$200 ¹⁶	70%
Retail non-preferred drug	50% up to \$200 ¹⁶	70%
Specialty	50% up to \$1,000	Not covered
Additional benefits		
Vision^{20,21}		
Pediatric exam & pediatric eyewear ^{22,23}	\$0	Not covered
Dental^{24,25}		
Pediatric dental ded (per individual)	\$50	n/a
Pediatric exams and cleanings ²⁶	\$0 no ded	Not covered
Pediatric basic, major, and orthodontia services ²⁷	50% after ded	Not covered

ded = Deductible

Health plan footnotes

Medical

- * Retail clinic services are subject to 0 percent coinsurance after deductible.
- 1 Certain plan benefits may be enhanced to comply with health care reform law/regulations. Eligible dependent children are covered to age 26.
 - 2 Embedded Deductible: Family deductible and out-of-pocket maximum apply when more than one person is covered under a plan. A covered family member only needs to satisfy his or her individual deductible before receiving plan benefits. Once the family deductible is met, then all covered family members will receive plan benefits. A covered family member only needs to satisfy his or her out-of-pocket maximum before that individual's benefits are covered in full. Once the family out-of-pocket is met, then all covered family members' benefits will be covered in full.
 - 3 There are no out-of-network services available except for emergency services.
 - 4 Out-of-Network providers may bill you for differences between the Plan allowance, which is the amount paid by Independence, and the actual charge of the provider. This amount may be significant. Claims payments for out-of-network providers are based on the lesser of the Medicare Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, payment is based on the lesser of the Independence applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is based on 50 percent of the actual charge of the provider with the exception of inpatient facility services. For inpatient facility covered services not recognized or reimbursed by Medicare or Independence's fee schedule, the amount is determined by Independence's fee schedule for the closest analogous covered service.
 - 5 Age and frequency schedules may apply. In order to get a preventive colonoscopy without having to pay any out-of-pocket costs, you must choose Preventive Plus providers and GI professionals (gastroenterologists or colon and rectal surgeons) that are not hospital-based to perform the preventive colonoscopy. To find a Preventive Plus provider, visit ibx.com/findadoctor.
 - 6 For PPO plans, visit limits are combined in- and out-of-network.
 - 7 Amount shown reflects the copay per day. There is a maximum of five copays per admission.
 - 8 For this plan, inpatient maternity hospital services are subject to 30 percent coinsurance after deductible.
 - 9 For PPO Bronze, inpatient maternity hospital services are subject to 50 percent coinsurance after deductible.

Keystone HMO Proactive

- 10 For Keystone HMO Silver Proactive the deductible is combined for Tiers 2 and 3.
- 11 For all Keystone HMO Proactive plans, the out-of-pocket maximum for Tiers 1, 2, and 3 are combined.
- 12 For Keystone HMO Proactive plans, if you are admitted to an in-network hospital from the emergency room, the out-of-pocket costs for inpatient hospital will apply based on the tier of the in-network hospital. If admitted to an out-of-network hospital following an emergency room admission, the Tier 3 in-network level of benefits will apply. Out-of-network providers for emergency services will be covered at the Tier 3 level of benefits.
- 13 For Keystone HMO Proactive plans, all in-network retail clinics are assigned to Tier 1, with the exception of Rite Aid Redi Clinic, which is assigned to Tier 3.

Prescription drugs

- 14 Prescription drug benefits are administered by FutureScripts, an independent company providing pharmacy benefit management services.
 - 15 No cost-sharing is required at participating retail and mail order pharmacies for certain preventive drugs (prescription and over-the-counter drugs with a doctor's prescription).
 - 16 Out-of-network benefits apply to prescriptions filled at non-participating pharmacies and the member must pay the full retail price for their prescription and then file a paper claim for reimbursement. The member should refer to their benefit booklet to determine the out-of-network coverage for their plan.
 - 17 This plan utilizes the FutureScripts Preferred Pharmacy Network — a subset of the national retail pharmacy network. It includes over 59,000 pharmacies, including most major chains and local pharmacies except Rite Aid. With plans that use the Preferred Pharmacy network, filling a prescription at a non-participating pharmacy is considered out-of-network, and members must pay the total cost upfront. They may be able to get reimbursed for part of this cost, but they will need to submit a claim and reimbursement will be at a lower rate.
 - 18 When a prescription drug is not available in a generic form, benefits will be provided for the brand drug and the member will be responsible for the cost-sharing for a brand drug. When a prescription drug is available in a generic form, benefits will be provided for that drug at the generic drug level only. If the member purchases a brand drug, the member will be responsible for paying the dispensing pharmacy the difference between the negotiated discount price for the generic drug and the brand drug plus the appropriate cost-sharing for a brand drug.
 - 19 Certain designated generic drugs are available at participating retail and mail order pharmacies for a reduced member cost-sharing (\$4 retail / \$8 mail order), after any applicable deductible.
- † For all plans, member pays cost-sharing per each fill unless out-of-pocket max has been met.
- ‡ Embedded Deductible: Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. Once an individual meets the individual deductible amount, claims for that individual will pay. Once the family deductible is met, claims for all individuals will pay. Once an individual meets the individual out-of-pocket maximum, benefits for that individual are covered in full. Once the family out-of-pocket maximum is met, benefits for all family members are covered in full. Individual deductible and out-of-pocket maximum apply when an individual is enrolled without dependents.

Additional benefits

- 20 Independence vision plans are administered by Davis Vision, an independent company.
- 21 Pediatric vision benefits expire at the end of the month in which the child turns 19.
- 22 One eye exam per calendar year period.
- 23 Pediatric spectacle lenses covered at no extra cost include: single vision, lined bifocal, lined trifocal, or lenticular lenses. For frames to be covered in full, choose from Davis Vision's Pediatric Frame Selection (available at most independent participating providers). Davis Vision Contact Lenses Collection is covered in full at participating independent providers.
- 24 Independence dental plans are administered by United Concordia Companies, Inc., an independent company.
- 25 Pediatric dental benefits are covered until the end of the calendar year in which the child turns 19.
- 26 One exam and one cleaning every six months per calendar year.
- 27 Only medically necessary orthodontia is covered.
- 28 Independence telemedicine benefits are administered by MDLIVE, an independent company.