

Personal Choice PPO 30 Copay



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	None	\$5,000/\$10,000
Coinsurance	20%	50%
Out-of-pocket maximum, individual/family (includes coinsurance only)	\$5,000/\$10,000	\$10,000/\$20,000

Preventive services

Mammogram	\$0	50%, no deductible
Pediatric immunizations (subject to office visit copay)	\$0	
Nutrition counseling (6 visits per year ¹)	\$0	50%, after deductible

Physician services

Primary care office visit	\$30	50%, after deductible
Specialist office visit	\$50	
Routine gynecological exam/Pap test (1 per year)	\$30	50%, no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	\$50	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)	\$50	

Hospital/other medical services

Inpatient hospital services/days	20%/unlimited days	50%, after deductible/70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	20%	20%, after in-network deductible
Outpatient surgery	20%	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	None	None
Generic formulary copay	\$10	50%, no deductible
Brand formulary copay	\$30	
Non-formulary copay	\$50	
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹	Up to \$2,500 per person per year	Up to \$2,500 per person per year

¹ Combined in and out of network

What's not covered?

- services not medically necessary;
- any treatment of substance abuse or mental illness, including serious mental illness;
- services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- maternity;
- routine eye care;
- immunizations for travel or employment;
- services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- private duty nursing;
- self-injectable drugs except as specified under the prescription drug benefits;
- Charges related to any medical condition or illness for which medical advice or treatment was recommended or received in the 12 months preceding the effective date of your plan policy are excluded for the first 12 months. If you have been continuously insured for the past 12 months by a participating Blue Cross or Blue Shield plan, or the past 18 months by another plan, you may be able to receive credit for all or part of the 12-month exclusion.

Note: Eligible unmarried dependent children are generally covered to age 19 or age 23 (if full-time students). See contract for additional details.

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**Independence
Blue Cross**

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.

Personal Choice PPO 2500 Deductible



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	\$2,500/\$5,000	\$5,000/\$10,000
Coinsurance, after deductible	20%	50%
Out-of-pocket maximum, individual/family (includes coinsurance only)	\$5,000/\$10,000	\$10,000/\$20,000

Preventive services

Mammogram	\$0, no deductible	50%, no deductible
Pediatric immunizations (subject to office visit copay)		
Nutrition counseling (6 visits per year ¹)		50%, after deductible

Physician services

Primary care office visit	\$30, no deductible	50%, after deductible
Specialist office visit	\$50, no deductible	
Routine gynecological exam/Pap test (1 per year)	\$30, no deductible	50%, no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	\$50, no deductible	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)		

Hospital/other medical services

Inpatient hospital services/days	20%, after deductible/ unlimited days	50%, after deductible/ 70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	20%, after deductible	20%, after in-network deductible
Outpatient surgery	20%, after deductible	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	None	None
Generic formulary copay	\$10	50%, no deductible
Brand formulary copay	\$30	
Non-formulary copay	\$50	
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹	Up to \$2,500 per person, per year	Up to \$2,500 per person, per year

¹ Combined in and out of network

What's not covered?

- services not medically necessary;
- any treatment of substance abuse or mental illness, including serious mental illness;
- services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- maternity;
- routine eye care;
- immunizations for travel or employment;
- services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- private duty nursing;
- self-injectable drugs except as specified under the prescription drug benefits;
- Charges related to any medical condition or illness for which medical advice or treatment was recommended or received in the 12 months preceding the effective date of your plan policy are excluded for the first 12 months. If you have been continuously insured for the past 12 months by a participating Blue Cross or Blue Shield plan, or the past 18 months by another plan, you may be able to receive credit for all or part of the 12-month exclusion.

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**Independence
Blue Cross**

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PPO 5000 Deductible



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance, after deductible	20%	50%
Out-of-pocket maximum, individual/family (includes deductible and coinsurance)	\$10,000/\$20,000	\$20,000/\$40,000

Preventive services

Mammogram	\$0, no deductible	50%, no deductible
Pediatric immunizations (subject to office visit copay)		
Nutrition counseling (6 visits per year ¹)		50%, after deductible

Physician services

Primary care office visit	\$30, no deductible	50%, after deductible
Specialist office visit	\$50, no deductible	
Routine gynecological exam/Pap test (1 per year)	\$30, no deductible	50%, no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	\$50, no deductible	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)		

Hospital/other medical services

Inpatient hospital services/days	20%, after deductible/ unlimited days	50%, after deductible/ 70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	20%, after deductible	20%, after in-network deductible
Outpatient surgery	20%, after deductible	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	None	None
Generic formulary copay	\$10	50%, no deductible
Brand formulary copay	\$30	
Non-formulary copay	\$50	
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹	Up to \$2,500 per person, per year	Up to \$2,500 per person, per year

¹ Combined in and out of network

What's not covered?

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- services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials;
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- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- maternity;
- routine eye care;
- immunizations for travel or employment;
- services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- private duty nursing;
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Note: Eligible dependent children are generally covered to age 26. See contract for additional details.

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**Independence
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PPO 3000 HSA



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	\$3,000/\$6,000	\$6,000/\$12,000
Coinsurance, after deductible	20%	50%
Out-of-pocket maximum, individual/family (includes deductibles, copays, and coinsurance)	\$5,000/\$10,000	\$10,000/\$20,000

Preventive services

Mammogram	\$0, no deductible	50% , no deductible
Pediatric immunizations (subject to office visit copay)		
Nutrition counseling (6 visits per year ¹)		50%, after deductible

Physician services

Primary care office visit	20%, after deductible	50%, after deductible
Specialist office visit		
Routine gynecological exam/Pap test (1 per year)	\$20, no deductible	50% , no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	20%, after deductible	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)		

Hospital/other medical services

Inpatient hospital services/days	20%, after deductible/ unlimited days	50%, after deductible/ 70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	20%, after deductible	20%, after in-network deductible
Outpatient surgery	20%, after deductible	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	None	None
Generic formulary copay	\$10	50%, no deductible
Brand formulary copay	\$30	
Non-formulary copay	\$50	
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹	Up to \$2,500 per person, per year	Up to \$2,500 per person, per year

¹ Combined in and out of network

What's not covered?

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- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- maternity;
- routine eye care;
- immunizations for travel or employment;
- services or supplies payable under workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- private duty nursing;
- self-injectable drugs except as specified under the prescription drug benefits;
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Personal Choice PPO 5000 HSA



Benefits per calendar year	You pay in-network	You pay out-of-network*
Deductible, individual/family	\$5,000/\$10,000	\$10,000/\$20,000
Coinsurance, after deductible	N/A	50%
Out-of-pocket maximum, individual/family (includes deductibles, copays, and coinsurance)	\$5,000/\$10,000	\$20,000/\$40,000

Preventive services

Mammogram	\$0, no deductible	50%, no deductible
Pediatric immunizations (subject to office visit copay)		
Nutrition counseling (6 visits per year ¹)		50%, after deductible

Physician services

Primary care office visit	\$0, after deductible	50%, after deductible
Specialist office visit		
Routine gynecological exam/Pap test (1 per year)	\$0, no deductible	50%, no deductible
Routine eye care	Not covered	Not covered
Spinal manipulations (20 visits per year ¹)	\$0, after deductible	50%, after deductible
Physical/occupational therapy (20 visits per year ¹)		

Hospital/other medical services

Inpatient hospital services/days	\$0, after deductible/ unlimited days	50%, after deductible/ 70 days
Maternity hospitalization	Not covered	Not covered
Emergency room (not waived if admitted)	\$0, after deductible	\$0, after in-network deductible
Outpatient surgery	\$0, after deductible	50%, after deductible
Ambulance		
Outpatient lab/pathology		
Routine radiology/diagnostic		
MRI/MRA, CT/CTA scan, PET scan		
Biotech/specialty injectables		
Durable medical equipment (each year you have coverage up to \$2,000, which includes up to \$1,000 for diabetic equipment and supplies)		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered

Continued

Prescription drug

Benefits per calendar year	You pay in-network	You pay out-of-network*
Prescription deductible, individual/family	Integrated with medical	Integrated with medical
Generic formulary copay	\$0, after deductible	50%, after deductible
Brand formulary copay		
Non-formulary copay		
Prescription mail order	Available	Available
Maximum prescription drug benefit ¹ , individual/family	None	None

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