

Medical Plan Highlights

BENEFIT	PERSONAL CHOICE HDHP PLAN		PERSONAL CHOICE BASIC HDHP PLAN	
	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*
Deductible Individual / Family	\$2,000 / \$4,000 ¹		\$3,000 / \$6,000 ¹	
Out-Of-Pocket Maximum Individual / Family	\$5,600 / \$11,200		\$5,600 / \$11,200	
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Office Visit Primary Care / Specialist	100% after deductible	80% after deductible	90% after deductible	80% after deductible
MDLIVE Telehealth	100% after deductible	Not Covered	90% after deductible	Not Covered
MDLIVE Telehealth Dermatology & Behavioral Health	100% after deductible	Not Covered	90% after deductible	Not Covered
Preventive Care	100% no deductible	80% no deductible	90% no deductible	80% no deductible
Emergency Room	100% after deductible	100% after deductible	90% after deductible	90% after deductible
Urgent Care	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Diagnostic X-Ray	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Laboratory	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Inpatient Hospitalization	100% after deductible	80% after deductible 70 inpatient days maximum	90% after deductible	80% after deductible 70 inpatient days maximum
Outpatient Surgical Facility Charges	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Inpatient Mental Health Care or Substance Abuse Treatment	100% after deductible	80% after deductible 70 inpatient days maximum	90% after deductible	80% after deductible 70 inpatient days maximum
Outpatient Mental Health Care or Substance Abuse Treatment (Facility and Clinic)	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Prescription Retail (30 Day)	(after deductible)	50% after deductible	(after deductible)	50% after deductible
Generic	\$10 copay		\$10 copay	
Brand	\$25 copay		\$25 copay	
Non-Formulary	\$45 copay		\$45 copay	
Prescription Mail Order (90 Day)	(after deductible)	Not Covered	(after deductible)	Not Covered
Generic	\$20 copay		\$20 copay	
Brand	\$50 copay		\$50 copay	
Non-Formulary	\$90 copay		\$90 copay	

*If you use out-of-network providers, Independence will pay the lesser of the Medicare Allowable Payment or the provider's charge for services rendered. The provider has the right to balance bill you the difference.

¹ Refer to page 4 for a description of how the HDHP and Basic HDHP plans deductibles apply differently for those with family coverage.

Note: This chart is a summary of options offered under the plan. For more information, please refer to the plan documents. In the event of a discrepancy between this summary and the plan documents, the plan documents will govern. Please refer to Benefitfocus for details regarding the Keystone POS plan.

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KEYSTONE HMO	PERSONAL CHOICE PPO PLAN	
	IN-NETWORK	OUT-OF-NETWORK*
None	\$0 / \$0	\$500 / \$1,000
\$1,000 / \$2,000	\$1,500 / \$3,000	\$3,000 / \$6,000
Unlimited	Unlimited	Unlimited
\$15 copay / \$25 copay	\$25 copay / \$40 copay	70% after deductible
\$5 copay	\$5 copay	Not Covered
\$20 copay	\$20 copay	Not Covered
100% covered	100% covered	70% no deductible
\$150 copay (waived if admitted)	\$150 copay (waived if admitted)	\$150 copay (waived if admitted)
\$105 copay	\$105 copay	70% after deductible
100% covered	\$40 copay	70% after deductible
100% covered	100% covered	70% after deductible
\$100 copay/day \$500 maximum/admission	\$150 copay/day \$750 maximum/admission	70% after deductible 70 inpatient days maximum
\$50 copay	\$150 copay	70% after deductible
\$100 copay/day \$500 maximum/admission	\$150 copay/day \$750 maximum/admission	70% after deductible 70 inpatient days maximum
\$25 copay	\$40 copay	70% after deductible
\$15 copay \$35 copay \$50 copay	\$15 copay \$35 copay \$50 copay	Covered 30% at a non-participating pharmacy
\$30 copay \$70 copay \$100 copay	\$30 copay \$70 copay \$100 copay	Not Covered

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