

# Medical Plan Highlights

BENEFIT	NEW for 2020!			
	PERSONAL CHOICE HDHP PLAN		PERSONAL CHOICE BASIC HDHP PLAN	
	IN-NETWORK	OUT-OF-NETWORK*	IN-NETWORK	OUT-OF-NETWORK*
<b>Deductible</b>				
Individual	\$2,000		\$3,000	
Family	\$4,000 <sup>1</sup>		\$6,000 <sup>1</sup>	
<b>Out-Of-Pocket Maximum</b>				
Individual	\$5,600		\$5,600	
Family	\$11,200		\$11,200	
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited
<b>Office Visit</b>				
Primary Care / Specialist	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Telemedicine (MDLIVE)</b>	100% after deductible	Not Covered	90% after deductible	Not Covered
<b>Preventive Care</b>	100% no deductible	80% no deductible	90% no deductible	80% no deductible
<b>Emergency Room</b>	100% after deductible	100% after deductible	90% after deductible	90% after deductible
<b>Urgent Care</b>	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Diagnostic X-Ray</b>	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Laboratory</b>	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Inpatient Hospitalization</b>	100% after deductible	80% after deductible 70 inpatient days maximum	90% after deductible	80% after deductible 70 inpatient days maximum
<b>Outpatient Surgical Facility Charges</b>	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Inpatient Mental Health Care or Substance Abuse Treatment</b>	100% after deductible	80% after deductible 70 inpatient days maximum	90% after deductible	80% after deductible 70 inpatient days maximum
<b>Outpatient Mental Health Care or Substance Abuse Treatment (Facility and Clinic)</b>	100% after deductible	80% after deductible	90% after deductible	80% after deductible
<b>Prescription Retail (30 Day)</b>				
Generic	\$10 copay	50% after deductible	\$10 copay	50% after deductible
Brand	\$25 copay		\$25 copay	
Non-Formulary	\$45 copay (after deductible)		\$45 copay (after deductible)	
<b>Prescription Mail Order (90 Day)</b>				
Generic	\$20 copay	Not Covered	\$20 copay	Not Covered
Brand	\$50 copay		\$50 copay	
Non-Formulary	\$90 copay (after deductible)		\$90 copay (after deductible)	

\*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.

<sup>1</sup> Refer to page 5 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 ONLY	IN-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
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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