

The Preferred Provider Organization

Summary of Benefits

Comcast Corporation - 2008

The Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to choose your own doctors and hospitals. You maximize your coverage by having care provided by preferred providers that participate in the BlueCard PPO® Program, these are called network providers. Of course, with the Preferred Provider Organization, you have the freedom to select providers who do not participate in the BlueCard® PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With the Preferred Provider Organization (PPO)...

- You do not need to enroll with a primary care physician
- You never need a referral

Benefit	In-Network	Out-of-Network ¹
DEDUCTIBLE		
Individual	\$0	\$500
Family	\$0	\$1,000
AFTER DEDUCTIBLE, PLAN PAYS		
	90%	80%
OUT-OF-POCKET MAXIMUM (Includes Deductible)		
Individual	\$880	\$2,440
Family	\$1,760	\$4,880
LIFETIME MAXIMUM		
	\$3 Million (combined in/out-of-network)	\$3 Million (combined in/out-of-network)
DOCTOR'S OFFICE VISITS		
Primary Care Services	\$15 Copayment	80%, after deductible
Specialist Services	\$25 Copayment	80%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN		
	\$15 Copayment	80%, NO deductible
PEDIATRIC IMMUNIZATIONS		
	100% ²	80%, NO deductible

1 Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by IBC to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

2 Office visit subject to copayment



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

www.ibx.com

Benefit	In-Network	Out-of-Network ¹
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age ³	100%	80%, NO deductible
MAMMOGRAM	100%	80%, NO deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year ³	100%	80%, after deductible
MATERNITY		
First OB visit	\$15 Copayment	80%, after deductible
Hospital	\$100 Copayment per admission, 90%	80%, after deductible
INPATIENT HOSPITAL SERVICES	\$100 Copayment per admission, 90%	80%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited
OUTPATIENT SURGERY	90%	80%, after deductible
EMERGENCY ROOM	90% after \$75 Copayment (Copayment waived if admitted)	90% after \$75 Copayment, NO deductible (Copayment waived if admitted)
URGENT CARE CENTER	\$35 Copayment, then 90%	80%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	80%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	90%	80%, after deductible
THERAPY SERVICES		
Physical, Speech and Occupational	90%	80%, after deductible
Cardiac Rehabilitation	90%	80%, after deductible
Pulmonary Rehabilitation	90%	80%, after deductible
Respiratory Therapy	90%	80%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum ³	90%	80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE \$500 calendar year maximum ³	90%	80%, after deductible
CHEMO/RADIATION/DIALYSIS	90%	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	90%	80%, after deductible
SKILLED NURSING FACILITY	90%	80%, after deductible

1 Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by IBC to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

3 Combined in/out-of-network

Benefit	In-Network	Out-of-Network ¹
HOSPICE AND HOME HEALTH CARE	90%	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	90%	80%, after deductible
HEARING AIDS Two units, up to \$1,000, every 36 months ³	90%	90%, NO deductible
HEARING AID ACCESSORIES Not applied to device maximum	90%	90%, NO deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
MENTAL HEALTH CARE		
Outpatient 25 visits per calendar year ³	\$25 Copayment	80%, after deductible
Inpatient 30 days per calendar year ³	\$100 Copayment per admission, 90%	80%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient \$1,000 per calendar year ³	50%	50%, after deductible
Inpatient \$20,000 per lifetime ³	\$100 Copayment per admission, 90%	80%, after deductible

1 Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by IBC to the provider. Under IBC contracts with hospitals and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the provider's actual charge.

3 Combined in/out-of-network

What Is Not Covered?

- Services not medically necessary
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service or supply
- Cosmetic services/supplies
- Routine foot care
- Supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- Dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- Vision care
- Military or occupational injuries or illness
- Benefits payable by the government, Medicare or through motor vehicle insurance
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Services or supplies that are experimental or investigative except routine costs associated with clinical trials
- Inpatient private duty nursing
- Alternative therapies/complementary medicine
- Maintenance of chronic conditions
- Immunizations required for employment or travel

This summary represents only a partial listing of the benefits and exclusions of the Independence Blue Cross 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 handbook carefully for a complete listing of the terms, limitations and exclusions of the program. If you need more information, please call 1-800-898-3556.

Services That Require Pre-Authorization

Service	In-Network (BlueCard® PPO provider)	Out-of-Network
ALL NON-EMERGENCY INPATIENT ADMISSIONS (Except maternity admissions)	Required	Required
OUTPATIENT SURGICAL PROCEDURES		
Bunionectomy	Required	NOT Required
Cataract Surgery	NOT Required	NOT Required
Laparoscopic Cholecystectomy	Required	NOT Required
Hemorrhoidectomy	Required	NOT Required
Hernia Repair	NOT Required	NOT Required
Arthroscopic Knee Surgery/Diagnostic Arthroscopy	Required	NOT Required
Ligation and Stripping of Varicose Veins	Required	NOT Required
Obesity Surgery	Required	Required
Prostate Surgery	NOT Required	NOT Required
Spinal/Vertebral Surgery	NOT Required	NOT Required
Submucous Resection (nasal surgery)	Required	NOT Required
Tonsillectomy and/or Adenoidectomy	Required	NOT Required
TRANSPLANTS	Required	Required
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	NOT Required	NOT Required
MRI/MRA	Required	Required
CT/CTA SCAN	Required	Required
PET SCAN	Required	Required
NUCLEAR CARDIAC STUDIES	Required	Required
OUTPATIENT THERAPIES: Speech, Cardiac, Pulmonary, Respiratory, Infusion	Required	NOT Required
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES: Skilled Nursing, Inpatient Hospice, Home Health, Birth Center	Required	Required
MENTAL HEALTH, SUBSTANCE ABUSE AND SERIOUS MENTAL ILLNESS TREATMENT		
Inpatient/Partial Facility	Required	Required
Outpatient	NOT Required	NOT Required
DAY REHABILITATION PROGRAMS	Required	Required
NONSURGICAL DENTAL	Required	Required
NON-EMERGENCY AMBULANCE	Required	NOT Required
DURABLE MEDICAL EQUIPMENT Purchase items (including repairs and replacements) over \$500, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)	Required	NOT Required
PROSTHETICS AND ORTHOTICS Purchase items (including repairs and replacements) over \$500 (excluding ostomy supplies)	Required	NOT Required
INFUSION THERAPY IN A HOME SETTING	Required	Required
INFUSION THERAPY DRUGS Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)	Required	Required

If you use a provider who is a BlueCard PPO network provider or an out-of-network provider, you must obtain pre-authorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain pre-authorization.

Call Independence Blue Cross at the pre-authorization telephone number listed on the back of your identification card to initiate pre-authorization.

You may be responsible for financial penalties if you do not pre-authorize services when you use a BlueCard PPO provider, or an out-of-network provider. There is a \$1,000 penalty for failure to pre-authorize inpatient services or treatment, and a 20% reduction in benefits for failure to pre-authorize outpatient services or treatment.

Pre-authorization is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the pre-authorization is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.