Gold health plans	Personal Choice® PPO Gold Preferred[2]	
Benefits per calendar year[1]	**You pay in-network**	**You pay out-of-network[4]**
Deductible — Individual/Family	$0/$0	$6,000/$12,000
Coinsurance	20%, unless otherwise noted	50%, unless otherwise noted
Out-of-pocket maximum — Individual/Family	$9,750/$19,500 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 visit — Office/Virtual	$15/$5	50% after ded/50% after ded
Specialist visit — Office/Virtual	$15/$5	50% after ded/50% after ded
Retail clinic	$15	50% after ded
Virtual care services from designated virtual provider[25]	$0	Not covered
Urgent care	$15	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]	$45/$45	50% after ded/50% after ded
Hospital and other medical services		
Inpatient hospital services (includes maternity)	$500 per day[7]	50% after ded
Inpatient professional services (includes maternity)	20%	50% after ded
Emergency room (for copay plans, copay waived if admitted)	$325	$325, no ded
Routine radiology/diagnostic — Freestanding/Hospital-based	$105/$105	50% after ded/50% after ded
MRI/MRA, CT/CTA scan, PET scan — Freestanding/Hospital-based	$300/$300	50% after ded/50% after ded
Biotech/Specialty injectables — Home or office/Outpatient	$120/$240	50% after ded/50% after ded
Infusion — Home or office/Outpatient	$45/$90	50% after ded/50% after ded
Durable medical equipment and prosthetics	50%	50% after ded
Outpatient mental health and substance abuse — Office visit/All other	$15/$45	50% after ded/50% after ded
Inpatient mental health and substance abuse	$500 per day[7]	50% after ded
Outpatient surgery		
Ambulatory surgical facility/Hospital-based	$300/$700	50% after ded/50% after ded
Outpatient lab and pathology		
Freestanding/Hospital-based	$10/$85	50% after ded/50% after ded
Prescription drugs[12,13]		
Deductible — Individual/Family	None	None
Low-cost generic[14]	$3	70%
Retail generic[14]	$20	70%
Retail preferred brand[14]	$100	70%
Retail non-preferred drug[14]	50%, up to $200	70%
Self-administered specialty drug	50%, up to $1,000	Not covered
Additional benefits		
Vision[17,18]		
Pediatric exam and pediatric eyewear[19,20]	$0	Not covered
Dental[21,22]		
Pediatric dental deductible (per individual)	$50	N/A
Pediatric exams and cleanings[23]	$0, no ded	Not covered
Pediatric basic and major/Orthodontia services[24,29]	50% after ded/50%, no ded	Not covered

Health plan footnotes

Medical

* For these plans, visit limits are combined for office and virtual care.

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/Out-of-pocket maximum: 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, 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 maximum is met, 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 Blue Cross, 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 Blue Cross applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or Independence Blue Cross'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 Blue Cross's fee schedule, the amount is determined by Independence Blue Cross'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. Enter your ZIP code where it says Location, and then select the tile labeled "Preventive Plus – Preventive+ Colonoscopy" under the main search section.

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.

Keystone HMO Proactive

8 For all Keystone HMO Proactive plans, the deductible is combined for Tiers 2 and 3.

9 For all Keystone HMO Proactive plans, the out-of-pocket maximum for Tiers 1, 2, and 3 is combined.

10 If a member is admitted to an in-network hospital from the emergency room, the cost-sharing for inpatient hospital care, including medical care provided by an in-network professional provider, will apply based on the tier level of the in-network hospital or in-network professional provider. If a member is admitted to an out-of-network hospital following an emergency room admission, the Tier 3 – Standard level of benefits will apply. For non-emergency care, members must use in-network providers.

11 For all Keystone HMO Proactive plans, all in-network retail clinics are assigned to Tier 1, with the exception of Walgreen's Health Clinic, which is assigned to Tier 3.

Prescription drugs

12 Our prescription drug plans are administered by an independent pharmacy benefits management (PBM) company.

13 No cost-sharing is required at in-network retail and mail order/home delivery pharmacies for certain preventive drugs (prescription and over-the-counter drugs with a doctor's prescription).

14 Out-of-network benefits apply to prescriptions filled at out-of-network pharmacies, and the member must pay the full retail price for their prescription and then file a claim for reimbursement. The member should refer to their benefit booklet to determine the out-of-network coverage for their plan.

15 This plan uses the Preferred Pharmacy network, with more than 57,000 pharmacies nationwide. If you have the Preferred Pharmacy network and fill a prescription at an out-of-network pharmacy, such as Walgreens, you will need to pay the up-front total cost at the pharmacy. You can then submit a claim, and you may be reimbursed for part of the cost.

16 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.

† Embedded deductible/Out-of-pocket maximum: 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

17 Independence Blue Cross vision plans are administered by Davis Vision, an independent company.

18 Pediatric vision benefits expire at the end of the month in which the child turns 19.

19 One eye exam per calendar year period.

20 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 in-network providers). Davis Vision Contact Lenses Collection is covered in full at in-network independent providers.

21 Independence Blue Cross dental plans are underwritten by QCC Insurance Company and Independence Dental Benefits are administered by Dominion Dental Services, Inc., an independent company.

22 Pediatric dental benefits are covered until the end of the calendar year in which the child turns 19.

23 One exam and one cleaning are covered every six months per calendar year.

24 Only medically necessary orthodontia is covered.

25 Virtual care from a designated virtual provider includes telemedicine, teledermatology, and telebehavioral health services offered through our virtual care provider, Teladoc Health, an independent company.

26 With the Adult Dental Premier plan IBX PPO 100/50/30/0 $1,000 (MAC) and IBX Active PPO 100/80/50/50 $1,500 (MAC), certain preventive services are not deducted from the annual benefit maximum. Please refer to your policy for additional details.

27 Discount is not available at Walmart, Sam's Club, and Costco.

28 Enhanced frame allowance is available at preferred sites.

29 There is no deductible for orthodontia.

Independence

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