Medical Plan Highlights 2023

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 Behavioral Health & Dermatology	100% after deductible	Not Covered	90% after deductible	Not Covered
Preventive Care	100% no deductible	80% no deductible	100% 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
Rehabilitation Therapy[2]	100% after deductible Limit 60 visits/year[2]	80% after deductible Limit 60 visits/year[2]	90% after deductible Limit 60 visits/year[2]	80% after deductible Limit 60 visits/year[2]
Inpatient Hospitalization	100% after deductible	80% after deductible 70 inpatient days max	90% after deductible	80% after deductible 70 inpatient days max
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 max	90% after deductible	80% after deductible 70 inpatient days max
Outpatient Mental Health Care or Substance Abuse Treatment *(Facility & Clinic)*	100% after deductible	80% after deductible	90% after deductible	80% after deductible
Prescription Retail *(30 Day)* Generic Brand Non-Formulary	(after deductible) $10 copay $25 copay $45 copay	50% after deductible	(after deductible) $10 copay $25 copay $45 copay	50% after deductible
Prescription Mail Order *(90 Day)* Generic Brand Non-Formulary	(after deductible) $20 copay $50 copay $90 copay	Not Covered	(after deductible) $20 copay $50 copay $90 copay	Not Covered

**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 3 for a description of how the HDHP and Basic HDHP plans deductibles apply differently for those with family coverage.*

[2] *Limits for Physical, Occupational and Speech Therapy and combined for in and out-of-network services. HDHP and Basic HDHP limits are combined for Physical and Occupational Therapy. HMO and PPO limits are combined for Physical, Occupational and Speech Therapy.*

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.

Medical Plan Highlights 2023

KEYSTONE HMO	PERSONAL CHOICE PPO PLAN	
IN-NETWORK ONLY	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
$15 copay	$15 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% covered Limit 60 consecutive days/condition/year[2]	Visits 1 – 30: $25 copay Visits 31+: $40 copay Limit 60 visits/year[2]	70% after deductible Limit 60 visits/year[2]
$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 max
$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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