Independence

PAISBOA Health Benefit Trust

Medical Benefit Highlights

HBT HD $2,500/$5,000, 80%

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Aggregate)[1]		
Individual/Family	$2,500/$5,000	$5,000/$10,000
Out-of-Pocket Maximum (See Footnote)[2]		
Individual/Family	$6,350/$12,700	$10,000/$20,000
Coinsurance	20%	50%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	50% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	50% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)	20% after deductible	50% after deductible
Specialist	20% after deductible	50% after deductible
Retail Health Clinic Visit	20% after deductible	50% after deductible
Urgent Care Visit	20% after deductible	50% after deductible
Virtual Care[3]	**In-Network**	**Out-of-Network**
Telemedicine	Covered	Not covered
Telebehavioral Health	Covered	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (60 visits/year)[4]		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Occupational Therapy (60 visits/year)[4]		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Speech Therapy (60 visits/year)[5]	20% after deductible	50% after deductible

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Emergency Services	In-Network	Out-of-Network
Emergency Room	20% after deductible	Covered at In-Network level
Emergency Ambulance	20% after deductible	Covered at In-Network level
Non-Emergency Ambulance	20% after deductible	50% after deductible

Hospital Services	In-Network	Out-of-Network
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6]	20% after deductible	50% after deductible
Observation Services	20% after deductible	50% after deductible
Maternity Hospital Services[6]	20% after deductible	50% after deductible
Inpatient Professional Services (includes Maternity)	20% after deductible	50% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Outpatient Professional Services	20% after deductible	50% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)[7]	20% after deductible	50% after deductible
Routine Radiology (X-Ray)[7]		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	20% after deductible	50% after deductible
Hospital Based	20% after deductible	50% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year)[5]	20% after deductible	50% after deductible
Acupuncture (18 visits/year)[5]	20% after deductible	50% after deductible
Standard Injectables	20% after deductible	50% after deductible
Allergy Injections	20% after deductible	50% after deductible
Biotech/Specialty Injectables		
Home/Office	20% after deductible	50% after deductible
Outpatient	20% after deductible	50% after deductible
Chemotherapy	20% after deductible	50% after deductible
Dialysis	20% after deductible	50% after deductible

Skilled Nursing Facility (120 days/year)[5]	20% after deductible	50% after deductible
Home Health	20% after deductible	50% after deductible
Hospice	20% after deductible	50% after deductible
Durable Medical Equipment (DME)	20% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	20% after deductible	50% after deductible
All Other Services	20% after deductible	50% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	20% after deductible	50% after deductible

1 Aggregate deductible: For family coverage, the entire family deductible must be met before copayments or coinsurance are applied for an individual member.

2 In-Network embedded out-of-pocket maximum: Each covered family member only needs to satisfy his or her individual out-of-pocket maximum, not the entire family out-of-pocket maximum. Out-of-Network aggregate out-of-pocket maximum: For family coverage, the entire family out-of-pocket maximum must be met before copayments or coinsurance are applied for an individual member.

3 Telemedicine services are provided through Doctor on Demand. Please refer to Doctor on Demand materials for additional information about coverage and member cost sharing.

4 Physical Therapy, Occupational Therapy, and Cognitive Therapy combined visit limit in and out-of-network.

5 Combined in and out-of-network.

6 Inpatient hospital out-of-network day limit combined for all inpatient medical, maternity, mental health, serious mental illness, and substance abuse services.

7 Office visit may be subject to copay

The Personal Choice® Preferred Provider Organization (PPO) gives you freedom of choice by allowing you to select your own doctors and hospitals. You maximize your coverage by accessing care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers who participate in the BlueCard® PPO program. If you access care from a provider who does not participate in our network, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

This summary represents only a partial listing of benefits and exclusions of the Medical 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 benefit booklet carefully for a complete listing of terms, limitations, and exclusions of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, please call the phone number listed on the back of your identification card, or log into your member portal account at **www.ibxpress.com<http://www.ibxpress.com.**

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: ʌચના: જો તમે ɀુજરાતી બોલતા હો, તો નિBɃભાષા સહાય સેવાઓ તમારા માટ ઉપલ ધ છે. 1-800-275-2583 કોલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: Úयान द: यिद आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल ध ह। कॉल कर 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):

توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go Diné Bizaad, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh. H0d77lnih koj8' 1-800-275-2583.

Urdu:

خبردار: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមេមម្តើ ចប់fរមណ៍ ៖ ្របស ិនេបីអ្នកនិយយភាMមន-ែខមរ ឬភាMែខមរ េនះ ជំនួយែផ្នកភាMនឹងមនផ្តល់ជូនដល់េrtr1 កអ្នកw1យឥត គិតៃថ្ល ទូរសពទេទលខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.