Independence

Medical Benefit Highlights

Personal Choice PPO Villanova University

Covered Services	Your Costs (You pay)	
Benefits per Contract Year	**In-Network**	**Out-of-Network**
Deductible (Embedded)[1] Individual/Family	$300/$900	$1,500/$4,500
Out-of-Pocket Maximum (Embedded)[2] Individual/Family	$3,000/$9,000	$6,000/$18,000
Coinsurance	10%	30%
Preventive Services	**In-Network**	**Out-of-Network**
Preventive Care	No charge no deductible	30% no deductible
Preventive Colonoscopy		
Preventive Plus Providers	No charge no deductible	Not covered
Hospital Based	No charge no deductible	30% no deductible
Physician Services	**In-Network**	**Out-of-Network**
Primary Care Physician (PCP)		
Office Visit	$30 no deductible	30% after deductible
Telemedicine Visit	$30 no deductible	30% after deductible
Specialist		
Office Visit	$50 no deductible	30% after deductible
Telemedicine Visit	$50 no deductible	30% after deductible
Retail Health Clinic Visit	$30 no deductible	30% after deductible
Urgent Care Visit	$50 no deductible	30% after deductible
Virtual Care[3]	**In-Network**	**Out-of-Network**
Telemedicine	$10 no deductible	Not covered
Teledermatology	$10 no deductible	Not covered
Telebehavioral Health	$10 no deductible	Not covered
Therapy Services	**In-Network**	**Out-of-Network**
Physical Therapy (30 visits/year)[4]		
Freestanding	$50 no deductible	30% after deductible
Hospital Based	$50 no deductible	30% after deductible
Occupational Therapy (30 visits/year)[4]		
Freestanding	$50 no deductible	30% after deductible
Hospital Based	$50 no deductible	30% after deductible
Speech Therapy (20 visits/year)[5]	$50 no deductible	30% after deductible
Emergency Services	**In-Network**	**Out-of-Network**
Emergency Room (copay waived if admitted)	$100 no deductible	Covered at In-Network level
Emergency Ambulance	No charge no deductible	Covered at In-Network level
Non-Emergency Ambulance	10% after deductible	30% after deductible
Hospital Services	**In-Network**	**Out-of-Network**
Inpatient Hospital Services (In-Network: 365 days/year; Out-of-Network: 70 days/year)[6]	10% after deductible	30% after deductible

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Observation Services	$100 no deductible	30% after deductible
Maternity Hospital Services[6]	10% after deductible	30% after deductible
Inpatient Professional Services (includes Maternity)	No charge no deductible	30% after deductible

Outpatient Surgery	In-Network	Out-of-Network
Freestanding	10% after deductible	30% after deductible
Hospital Based	10% after deductible	30% after deductible
Outpatient Professional Services	No charge no deductible	30% after deductible

Outpatient Diagnostics	In-Network	Out-of-Network
Diagnostic Medical (EKG)	$100 no deductible	30% after deductible
Routine Radiology (X-Ray)		
Freestanding	$30 no deductible	30% after deductible
Hospital Based	$30 no deductible	30% after deductible
Advanced Imaging (MRI/MRA,CT/CTA Scan, PET Scan)		
Freestanding	$50 no deductible	30% after deductible
Hospital Based	$50 no deductible	30% after deductible

Outpatient Lab and Pathology	In-Network	Out-of-Network
Freestanding	No charge no deductible	30% after deductible
Hospital Based	No charge no deductible	30% after deductible

Other Medical Services	In-Network	Out-of-Network
Spinal Manipulations (20 visits/year)[5]	$50 no deductible	30% after deductible
Acupuncture (18 visits/year)[5]	$50 no deductible	30% after deductible
Standard Injectables	No charge no deductible	30% after deductible
Allergy Injections	No charge no deductible	30% after deductible
Biotech/Specialty Injectables		
Home/Office	$50 no deductible	30% after deductible
Outpatient	10% after deductible	30% after deductible
Chemotherapy	No charge no deductible	30% after deductible
Dialysis	No charge no deductible	30% after deductible
Skilled Nursing Facility (120 days/year)[5]	10% after deductible	30% after deductible
Home Health	10% after deductible	30% after deductible
Hospice	10% after deductible	30% after deductible
Durable Medical Equipment (DME)	30% after deductible	50% after deductible
Mental Health – Outpatient (includes serious mental illness and substance abuse)		
Office Visit	$30 no deductible	30% after deductible
All Other Services	$30 after deductible	30% after deductible
Mental Health – Inpatient (includes serious mental illness and substance abuse)[6]	10% after deductible	30% after deductible

1 Embedded deductible: Each covered family member only needs to satisfy his or her individual deductible, not the entire family deductible, prior to receiving plan benefits.

2 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.

3 Telemedicine is provided by a designated telemedicine provider, please visit www.ibx.com/findcarenow.

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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.

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, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

Benefits may be changed by Independence Blue Cross to comply with applicable federal/state laws and regulations.

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to **http://www.ibx.com/preapproval** or call the phone number that is listed on the back of your identification card.

Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross - Independent licensees of the Blue Cross and Blue Shield Association. **www.ibx.com**

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Vision Benefit Highlights

Vision Care 150: 12/12/12-Voluntary

Covered Services	Your Costs (You pay)	
Benefits	**In-Network[1]**	**Out-of-Network**
Annual Plan Maximum	Unlimited	Unlimited
Deductible (Individual/Family)	$0/$0	$0/$0
Out-of-Pocket Maximum (Individual/Family)	$0/$0	$0/$0

Exam	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	1 / Contract Year	1 / Contract Year
Routine Eye Exam at Davis Participating Providers	No charge	$35 Reimbursement

Lenses	**In-Network[1]**	**Out-of-Network[2]**
Benefit Frequency	1 / Contract Year	1 / Contract Year
Single Vision Lenses	$20	$40 Reimbursement
Bifocal Lenses	$20	$60 Reimbursement
Trifocal Lenses	$20	$80 Reimbursement
Lenticular Lenses	$20	$100 Reimbursement
Lens Options[3]		
Standard Progressive Lenses	No charge	$60 Reimbursement
Premium Progressive Lenses	$40	$60 Reimbursement
Ultra Progressive Lenses	$90	$60 Reimbursement
Ultimate Progressive Lenses	$175	$60 Reimbursement
Polycarbonate Lenses - Single Vision[4]	No charge	Not applicable
Polycarbonate Lenses - Multifocal Vision	No charge	Not applicable
Photosensitive Lenses - Single Vision	$65	Not applicable
Photosensitive Lenses - Multifocal Vision	$65	Not applicable
High-Index Lenses	$55	Not applicable
High-Index 1.74 Lenses	$120	Not applicable
Blue Light Lenses	$15	Not applicable
Polarized Lenses	$75	Not applicable
Lens Coatings		
Tinted Plastic Lenses	No charge	Not applicable
UV-Coated Lenses	No charge	Not applicable
Scratch-Resistant Coating Single-Vision Lenses	No charge	Not applicable
Scratch-Resistant Coating Multifocal Lenses	No charge	Not applicable
Scratch-Protection Plan Single Vision Lenses	$20	Not applicable
Scratch-Protection Plan Multifocal Vision Lenses	$40	Not applicable
Anti-Reflective Standard Lenses	$35	Not applicable
Anti-Reflective Premium Lenses	$48	Not applicable
Anti-Reflective Ultra Lenses	$60	Not applicable
Anti-Reflective Ultimate Lenses	$85	Not applicable

Frames	**In-Network[1]**	**Out-of-Network**
Benefit Frequency	1 / Contract Year	1 / Contract Year
Davis Collection Fashion Frames	No charge	Not applicable
Davis Collection Designer Frames	No charge	Not applicable
Davis Collection Premier Frames	No charge	Not applicable
Non-Davis Collection Frames	Up to $270 Allowance (plus a 20% discount on overage)[5]	$100 Reimbursement

Reference ID: 1004163406012021

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Visionworks Frames Option	No charge	Not applicable

Contact Lenses (in lieu of glasses)	In-Network[1]	Out-of-Network
Benefit Frequency	1 / Contract Year	1 / Contract Year
Davis Collection Standard Daily Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Specialty Contact Lenses & Evaluation	No charge	Not applicable
Davis Collection Disposable Contact Lenses & Evaluation	No charge	Not applicable
Non-Davis Collection Contact Lenses & Evaluation	Contacts: Up to $250 Allowance; Evaluation: Up to $60 Allowance; (plus a 15% discount on overage)[5]	$105 Reimbursement
Medically-Necessary Contact Lenses[6]	No charge	$225 Reimbursement

1 Participating Davis provider benefit.

2 Lens Options are subject to out-of-network base lens reimbursement. See your benefit booklet for reimbursement amounts.

3 Spectacle lens options are available at most participating providers and member pays fixed discounted prices.

4 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/6.00 diopters are covered at no cost.

5 Member is responsible for balance. Additional discounts not applicable at Walmart, Costco, or Sam's Club locations.

6 Covered with prior approval.

This summary represents only a partial listing of benefits of the Vision Care Program described in this summary. If your employer purchases another program, the benefits may differ. Also, benefits may be further defined by the vision policy. As a result, this vision plan may not cover all of your vision or health care expenses. Read your contract/member benefit booklet carefully for a complete listing of terms and limitations of the program. For more information about your coverage, or to get a copy of the complete terms of coverage, visit **www.ibx.com/LGBooklet** or call **1-800-ASK-BLUE** (TTY: 711).

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Administered by Davis Vision.

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