

Summary of health plan limitations and precertification requirements

Limitations*	
Therapy services Physical and occupational therapy – 30 visits per calendar year Cardiac rehabilitation – 36 visits per calendar year Pulmonary rehabilitation – 36 visits per calendar year Speech therapy – 20 visits per calendar year Orthoptic/Pleoptic therapy – 8 sessions lifetime maximum	Mental Health care Outpatient – 20 visits per calendar year Inpatient – 30 days per calendar year
Spinal manipulations – 20 visits per calendar year	Serious Mental Illness care Outpatient – 60 visits per calendar year Inpatient – 30 days per calendar year
Outpatient private-duty nursing – 360 hours per calendar year	Substance abuse treatment Outpatient/Partial Facility Visits – 60 visits per calendar year, 120 visits lifetime. Rehabilitation – 30 days per calendar year, 90 days per lifetime Detoxification – 7 days per admission, 4 admissions per lifetime
Skilled Nursing Facility – 120 days per calendar year	* For Personal Choice®, combined in-/out-of-network maximum.

Precertification requirements	
Inpatient services Surgical and nonsurgical inpatient admissions Acute rehabilitation Skilled Nursing Facility Inpatient hospice Maternity admission (for notification only)	Prosthetics and orthotics Purchase items (including repairs and replacements) more than \$500 (excluding ostomy supplies)
Outpatient facility/Office services (other than inpatient) MRI/MRA CT/CTA scan PET scan Nuclear cardiac studies Hysterectomy Cataract surgery Nasal surgery for submucous resection and septoplasty Transplants (except cornea) Comprehensive outpatient pain management programs (including epidural injections) Obesity surgery Sleep studies Uvulopalatopharyngoplasty (including laser-assisted) Day rehabilitation programs Dental services as a result of accidental injury	Durable medical equipment Purchase items (including repairs and replacements) more than \$500, and all rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)
All Home-Care Services (including infusion therapy in the home)	Reconstructive procedures and potentially cosmetic procedures Abdominoplasty Augmentation mammoplasty Blepharoplasty Chemical peels Dermabrasion Excision of redundant skin Keloid removal Lipectomy/Liposuction Orthognathic surgery procedures Mastopexy Otoplasty Panniculectomy Reduction mammoplasty Removal or reinsertion of breast implants Rhinoplasty Surgery for varicose veins Scar revision Subcutaneous mastectomy for gynecomastia
Infusion therapy drugs Administered in an outpatient facility or in a professional provider's office (see list included in your open enrollment packet)	Mental Health/Serious Mental Illness/ Substance Abuse Mental health and Serious mental illness treatment (Inpatient/Outpatient/Partial hospitalization) Substance abuse treatment (Inpatient/Outpatient/Partial hospitalization)
Birthing center (for notification only)	
Elective (nonemergency) ambulance transport	
Outpatient private-duty nursing	

This represents only a summary of the limitations and precertification requirements under Independence Blue Cross Programs. If you need more information, please call 215-241-3400.

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield – independent licensees of the Blue Cross and Blue Shield Association.

High-Deductible Health Plans

Flexible benefits solutions for large group customers

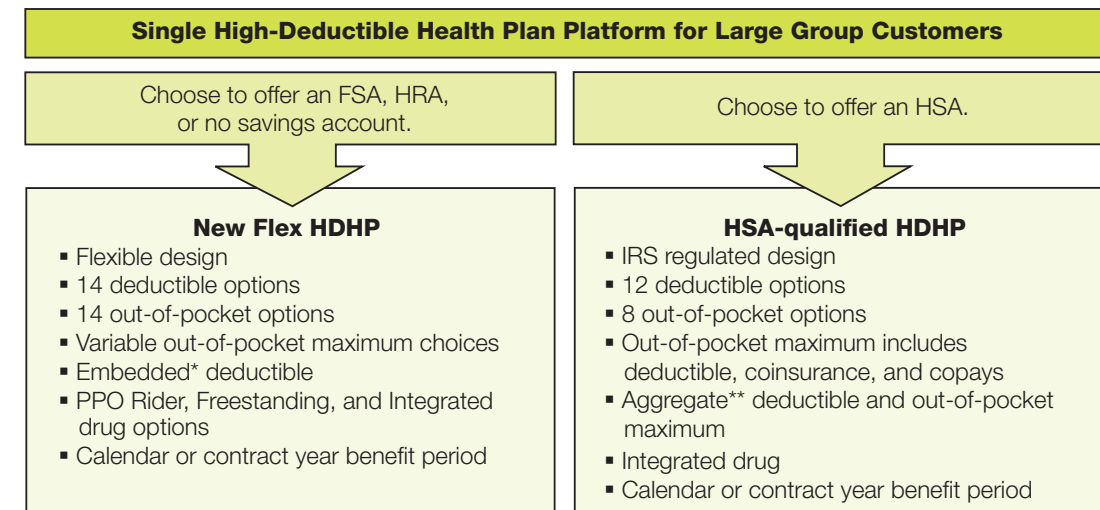
Flex our benefits offerings, and create the plan that fits your needs

Looking to reduce the cost of your health insurance? With our Personal Choice® PPO High-Deductible Health Plan (HDHP) platform, you have the ultimate freedom to create a benefits plan that meets your needs and budget.

Using our two extensive product menus—the new Flex HDHP menu and the HSA-qualified HDHP menu—you can adjust cost-sharing amounts, pair with a BlueSaverSM Health Account, and customize other benefit features to meet your price.

Designing a High-Deductible Health Plan

One HDHP platform, two cost-sharing menus, hundreds of choices!



Choose a cost-sharing menu: Personal Choice® Flex HDHP or HSA-qualified HDHP

The best way to decide if you should select from the Flex HDHP menu or the HSA-qualified HDHP menu, is to determine which health plan features are most important to you.

Decision Point	Flex HDHP	HSA-qualified HDHP
What type of BlueSaver SM Health Account are you looking for?	<input type="checkbox"/> FSA <input type="checkbox"/> HRA	<input type="checkbox"/> HSA
How do you want your deductible to accumulate?	Embedded*	Aggregate**
What type of prescription drug coverage are you looking for?	<input type="checkbox"/> PPO Drug Rider <input type="checkbox"/> Freestanding Drug <input type="checkbox"/> Integrated Drug	<input type="checkbox"/> Integrated Drug
How do you want your out-of-pocket maximum to be calculated?	<input type="checkbox"/> Coinsurance only <input type="checkbox"/> Coinsurance and deductible <input type="checkbox"/> Coinsurance, deductible, and copayments	<input type="checkbox"/> Coinsurance, deductible, and copayments

* **Embedded Deductible** – Once one person meets the individual deductible amount, claims for that person are paid even though the full family deductible may not have been met.

** **Aggregate Deductible** – In order for the benefit payment to start, the entire family deductible must be met.



Flex HDHP Menu

New menu, more choices!

1. Choose member cost-sharing for network services

Deductible – Applies to all services except preventive care

Single \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$3,000 \$5,600
 Family 2x single deductible 3x single deductible

Coinsurance – Applies to all services except preventive care

100%/0% 90%/10% 80%/20% 70%/30%

Out-of-pocket maximum

Single \$1,000 \$2,000 \$3,000 \$4,000 \$5,600 \$8,000 \$11,200
 Family 2x single out-of-pocket maximum 3x single out-of-pocket maximum

Preventive care – Deductible and coinsurance do not apply to preventive care. The following services are covered in full or with a copayment:

- Preventive visits (pediatric and adult) – \$20 copayment
- Routine Gyn/Pap – \$20 copayment
- Mammography – covered 100%
- Pediatric immunizations – covered 100%

2. Choose out-of-network benefits

Deductible

Single \$1,000 \$2,000 \$2,500 \$3,000 \$4,000 \$5,000 \$8,000
 Family 2x single deductible 3x single deductible

Coinsurance – Applies to all services except preventive care

80%/20% 70%/30% 60%/40% 50%/50%

Out-of-pocket maximum

Single \$4,000 \$5,000 \$6,000 \$8,000 \$10,000 \$16,000
 Family 2x single out-of-pocket maximum 3x single out-of-pocket maximum

3. Decide how your out-of-pocket maximum is calculated – Applies to in- and out-of-network benefits

Coinsurance only Coinsurance and deductible Coinsurance, deductible, and copayments

4. Select a benefit period

Calendar year Contract year

5. Choose to offer prescription drug coverage* (optional)

a. Decide to offer the Select Drug Program[®] base product

PPO Drug Rider Freestanding Drug

b. Determine whether you want to include contraceptive coverage

Yes No

c. Select generic formulary copay

\$0** \$2** \$5 \$10 \$15

d. Choose brand formulary copay (A \$10 minimum difference between the generic formulary and brand formulary copay is required.)

\$15 \$20 \$25 \$30 \$40 \$45 \$50

e. Select non-formulary copay (A \$15 minimum difference between the brand formulary and non-formulary copay is required.)

\$30 \$35 \$40 \$45 \$50 \$60
 \$70 \$75 \$80 \$90 \$100

6. Choose to offer a Blue SaverSM FSA or HRA to your employees (optional)

HRA FSA Both¹



a. Decide to offer integrated prescription drug coverage

Medications filled at a network pharmacy are subject to the network deductible and coinsurance. When using an out-of-network pharmacy, medications are subject to the out-of-network deductible and coinsurance. Members will receive up to a 30-day supply of their medication at a retail pharmacy.

Same as medical coinsurance/deductible

After deductible, \$5 generic formulary/\$20 brand formulary/\$45 non-formulary brand

* Standard procedures that support safe prescribing apply, such as prior authorization requirements, age and gender edits, and quantity level limits. For more information, go to www.ibx.com.

** For the \$0 and \$2 generic formulary copay options, the brand formulary copay option must be \$25 and there must be a \$25 minimum difference between the brand formulary and non-formulary copay amount.

¹ If offering both an FSA and HRA, keep in mind that the same expense cannot be reimbursed under both the FSA and HRA.

HSA-Qualified HDHP Menu

Same menu, new choices!

1. Choose member cost-sharing for network services

Deductible¹ – Applies to all services except preventive care (Aggregate: Entire family deductible must be met prior to benefit payment.)

Single \$1,500 \$2,000 \$2,500 \$3,000 \$3,500 \$5,600
 Family 2x single deductible 3x single deductible **NEW!**

Coinsurance² – Applies to all services except preventive care

100%/0% 90%/10% 80%/20% 70%/30%

Out-of-pocket maximum¹ (adjusted annually) – Includes deductibles, coinsurance, and copayments

Single \$2,000 \$3,000 \$4,000 \$5,600
 Family 2x single out-of-pocket maximum 3x single out-of-pocket maximum **NEW!**

Preventive care – Deductible and coinsurance do not apply to preventive care. The following services are covered in full or with a copayment:

- Preventive visits (pediatric and adult) – \$20 copayment
- Routine Gyn/Pap – \$20 copayment
- Mammography – covered 100%
- Pediatric immunizations – covered 100%

2. Choose out-of-network benefits

Deductible (Aggregate: Entire family deductible must be met prior to benefit payment.)

Single \$2,000 \$2,500 \$3,000 \$4,000 \$5,000 \$8,000
 Family 2x single deductible 3x single deductible **NEW!**

Coinsurance² – Applies to all services except preventive care

80%/20% 70%/30% 60%/40% 50%/50%

Out-of-pocket maximum – Includes deductibles, coinsurance, and copayments

Single \$4,000 \$5,000 \$6,000 \$8,000 \$10,000 \$16,000
 Family 2x single out-of-pocket maximum 3x single out-of-pocket maximum **NEW!**

3. Select benefit period **NEW!**

Calendar year Contract year

4. Choose to offer integrated prescription drug coverage* (optional)

Medications filled at an in-network pharmacy are subject to the network deductible. When using an out-of-network pharmacy, medications are subject to the out-of-network deductible and coinsurance. Members will receive up to a 30-day supply of their medication at a retail pharmacy.

Same as medical coinsurance After deductible, \$5 generic formulary/\$20 brand formulary/\$45 non-formulary brand

5. Choose to offer a Health Savings Account (HSA) to your employees (optional)

Yes No

Creating a BlueSaverSM HSA Solution

Pair an HSA-qualified HDHP with an HSA to help employees save money for medical expenses through tax-free contributions. Independence Blue Cross has a preferred relationship with The Bancorp Bank, an independent company, to provide HSA services to our members, but you may choose to offer an HSA through any qualified trustee or custodian. Bancorp HSA features include:

- No application or account set-up fees
- Online access to monitor savings and expenses
- Optional line of credit available to cover HSA shortfalls
- Free, no-annual-fee Visa[®] Debit Card and checks to get access to funds
- No monthly account maintenance fee³
- Invest HSA funds through National Financial Services
- Earn interest with first deposit⁴
- Toll-free 24/7 Customer Service

To learn more, visit the Bancorp website at: www.mybancorphsa.com

¹ Single deductibles and out-of-pocket maximum apply when an individual is enrolled without dependents. Family deductible and out-of-pocket maximum apply when an individual and one or more dependents are enrolled. Prior to benefits being paid, the entire family deductible must be met.

² The percentage for in-network and out-of-network reimbursement shown represents a percentage of the plan allowances, not the provider's actual charge. For more information about the PPO plan allowance, see the definition of Covered Expense in your PPO group contract. Out-of-network providers may also bill a member for the difference between the plan allowance, which is the amount paid by the plan, and the provider's actual charge. The difference may be significant.

³ Standard banking fees apply, e.g., insufficient funds.

⁴ Interest paid on balances over \$1.00

* Standard procedures that support safe prescribing apply, such as prior authorization requirements, age and gender edits, and quantity level limits. For more information, go to www.ibx.com.

All enrollments subject to underwriting guidelines. The plans outlined represent only a partial listing of benefits. These managed care plans may not cover all health care expenses. Read your contract carefully to determine which health care services are covered. If you need more information, please call 215-241-3400.