

## What's not covered?

- services not medically necessary;
- any treatment of substance abuse or mental illness, including serious mental illness;
- services or supplies that are experimental or investigative, except routine costs associated with qualifying clinical trials;
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices;
- assisted fertilization techniques, such as in vitro fertilization, GIFT, and ZIFT;
- reversal of voluntary sterilization;
- alternative therapies, such as acupuncture;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- treatment of obesity, except for surgical treatment of morbid obesity when medically necessary;
- routine foot care, except for medically necessary treatment of peripheral vascular disease and/or peripheral neuropathic disease including, but not limited to, diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- contraceptive devices;
- immunizations for travel or employment;
- services or supplies payable under Workers' compensation, motor vehicle insurance, or other legislation of similar purpose;
- cosmetic services/supplies;
- outpatient services that are not performed by your primary care physician's designated provider;
- private duty nursing;
- self-injectable drugs are excluded under medical programs. However, they are covered under the prescription drug benefit;
- charges related to any medical condition or illness for which medical advice or treatment was recommended or received during a certain amount of time (90 days for HMO, 12 months for PPO) preceding the effective date of your plan policy is excluded for the first 12 months, except for applicants under 19 and dependents under 19. If you have been continuously insured for 12 months by a participating Blue Cross® or Blue Shield® plan, or the past 18 months by another plan (without a break in coverage of more than 63 days prior to the current application), you may be able to receive credit for all or part of the 12 month exclusion. To learn more about preexisting condition exclusions and how they can be reduced through creditable coverage, visit [www.ibx4you.com/importantinfo](http://www.ibx4you.com/importantinfo).

In addition, the following benefits are not covered for PPO plans:

- maternity care
- routine eye care

NOTE: Dependent children are generally covered to age 26. See contract for additional details.

# Benefits summary for individuals and families Copay plans



We're here for you every step of the way.



HMO products underwritten and administered by Keystone Health Plan East.  
Personal Choice PPO products underwritten and administered by QCC Insurance Company. Subsidiaries of  
Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.

# Copay plans

	HMO 30 Copay	HMO 20 Copay	HMO 15 Copay	HMO 10 Copay	Personal Choice PPO 30 Copay	
Benefits per calendar year	You pay	You pay	You pay	You pay	You pay in-network	You pay out-of-network**
Deductible, individual/family	None	None	None	None	None	\$5,000/\$10,000
Coinsurance, after deductible					20%	50%
Out-of-pocket maximum, individual/family					\$5,000/\$10,000 Includes coinsurance	\$10,000/\$20,000 Includes deductible and coinsurance

## Preventive services

Mammogram (no referral required)	\$0	\$0	\$0	\$0	\$0	50%, no deductible
Pediatric immunizations						50%, after deductible
Nutrition counseling (6 visits per year <sup>†</sup> )						50%, no deductible
Routine gynecological exam/Pap test (no referral required, 1 per year <sup>†</sup> )						

## Physician services

Primary care office visit	\$30	\$20	\$15	\$10	\$30	50%, after deductible
Specialist office visit	\$50	\$30	\$25	\$20	\$50	
Routine eye exam (once every two years)	\$35 benefit*	\$35 benefit*	\$35 benefit*	\$35 benefit*	Not covered	Not covered
Eyeglasses or contact lenses (once every two years)						
Spinal manipulations <sup>‡</sup>	\$50 (20 visits per year)	\$30 (20 visits per year)	\$25 (20 visits per year)	\$20 (20 visits per year)	\$50 (20 visits per year)	50%, after deductible (20 visits per year)
Physical/occupational therapy <sup>‡</sup>	\$50 (30 visits per year)	\$30 (30 visits per year)	\$25 (30 visits per year)	\$20 (30 visits per year)	\$50 (20 visits per year)	50%, after deductible (20 visits per year)

## Hospital/other medical services

Inpatient hospital services	\$500 <sup>†</sup>	\$400 <sup>†</sup>	\$200 <sup>†</sup>	\$100 <sup>†</sup>	20%/unlimited days	50%, after deductible/70 days
Maternity hospitalization					Not covered	Not covered
Emergency room (not waived if admitted)	\$200	\$100	\$100	\$100	20%	20%, after in-network deductible
Outpatient surgery	\$500	\$400	\$200			
Ambulance	\$0	\$0	\$0	\$0	20%	50%, after deductible
Outpatient lab/pathology						
Routine radiology/diagnostic						
MRI/MRA, CT/CTA scan, PET scan	\$50	\$30	\$25	\$20		
MRI/MRA, CT/CTA scan, PET scan	\$100	\$60	\$50	\$40		
Biotech/specialty injectables	\$125	\$100	\$75	\$50		
Durable medical equipment	50%	50%	50%	50%		
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

## Prescription drug

Prescription deductible, individual/family	\$400/\$1200	\$250/\$750	\$100/\$300	\$100/\$300	None	None
Generic formulary copay	\$10, after prescription deductible	\$10, after prescription deductible	\$10, after prescription deductible	\$10, after prescription deductible	\$10	50%, no deductible
Brand formulary copay	30% coinsurance, \$250 maximum copay, after prescription deductible	30% coinsurance, \$250 maximum copay, after prescription deductible	30% coinsurance, \$250 maximum copay, after prescription deductible	30% coinsurance, \$250 maximum copay, after prescription deductible	35% coinsurance, \$250 maximum copay	
Non-formulary copay	40% coinsurance, \$250 maximum copay, after prescription deductible	40% coinsurance, \$250 maximum copay, after prescription deductible	40% coinsurance, \$250 maximum copay, after prescription deductible	40% coinsurance, \$250 maximum copay, after prescription deductible	45% coinsurance, \$250 maximum copay	
Prescription mail order	Available	Available	Available	Available	Available	Not available
Maximum prescription drug benefit, individual/family	None	None	None	None		None

\*Paid-in-full benefit available with select group of frames at Davis Vision participating providers. Davis Vision is an independent company that administers the vision program.

\*\* It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. Out-of-network, non-participating providers may bill you for differences between the plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on Independence Blue Cross's (IBC's) own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with providers, hospitals, and other facility providers, IBC pays using bulk purchasing arrangements that save money at the end of the year but do not produce a uniform discount for each individual claim. Therefore, the amount paid by IBC at the time of any given claim may be more or it may be less than the amount used to calculate your liability.

† Amount shown reflects the copayment per day. There is a maximum of five copayments per admission.

‡ Maximums shown are combined for in- and out-of-network care.

Certain plan benefits may be enhanced in order to comply with health care reform legislation.