

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.

This summary represents only a partial listing of benefits and exclusions. Benefits and exclusions may be further defined by medical policy. This managed care plan may not cover all your health care expenses.

Read your contract/subscriber agreement carefully to determine which health care services are covered. If you need more information, please call 1-800-263-1410.

For questions or to apply, contact your broker.



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.

Benefits at a glance

This summary represents in-network benefits only. For a complete listing of out-of-network benefits for the Personal Choice® PPO plans, contact your broker.

	HMO 30 Copay	HMO 20 Copay	HMO 15 Copay	HMO 10 Copay	Personal Choice PPO 30 Copay	HMO 5000	HMO 2500	HMO 1500	Personal Choice PPO 8000	Personal Choice PPO 5000	Personal Choice PPO 2500
Benefits per calendar year	You pay	You pay	You pay	You pay	You pay in-network	You pay	You pay	You pay	You pay in-network	You pay in-network	You pay in-network
Deductible, individual/family	None	None	None	None	None	\$5,000/\$10,000	\$2,500/\$5,000	\$1,500/\$3,000	\$8,000/\$16,000	\$5,000/\$10,000	\$2,500/\$5,000
Coinsurance, after deductible					20%	30%, unless otherwise noted	30%, unless otherwise noted	30%, unless otherwise noted	20%, after deductible	20%	20%
Out-of-pocket maximum, individual/family					\$5,000/\$10,000 Includes coinsurance	\$7,500/\$15,000 Includes coinsurance only	\$5,000/\$10,000 Includes coinsurance only	\$5,000/\$10,000 Includes coinsurance only	\$12,000/\$24,000 Includes deductible and coinsurance	\$10,000/\$20,000 Includes deductible and coinsurance	\$5,000/\$10,000 Includes deductible and coinsurance

Preventive services

Mammogram (no referral required)	\$0	\$0	\$0	\$0	\$0	\$0, no deductible	\$0, no deductible	\$0, no deductible	\$0, no deductible	\$0, no deductible	\$0, no deductible
Pediatric immunizations											
Nutrition counseling (6 visits per year*)											
Routine gynecological exam/Pap test (no referral required, 1 per year*)											

Physician services

Primary care office visit	\$30	\$20	\$15	\$10	\$30	\$30, no deductible	\$30, no deductible	\$30, no deductible	\$25, no deductible	\$30, no deductible	\$30, no deductible
Specialist office visit	\$50	\$30	\$25	\$20	\$50	\$50, no deductible	\$50, no deductible	\$50, no deductible	20%, after deductible	\$50, no deductible	\$50, no deductible
Routine eye exam (once every two years)					Not covered	\$50, no deductible	\$50, no deductible	\$50, no deductible	Not covered	Not covered	Not covered
Eyeglasses or contact lenses (once every two years)	\$35 benefit*	\$35 benefit*	\$35 benefit*	\$35 benefit*	\$50 (20 visits per year)	\$35 benefit*	\$35 benefit*	\$35 benefit*	20%, after deductible (20 visits per year)	Not covered	Not covered
Spinal manipulations*	\$50 (20 visits per year)	\$30 (20 visits per year)	\$25 (20 visits per year)	\$20 (20 visits per year)		\$50, no deductible (20 visits per year)	\$50, no deductible (20 visits per year)	\$50, no deductible (20 visits per year)		\$50, no deductible (20 visits per year)	\$50, no deductible (20 visits per year)
Physical/occupational therapy*	\$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, no deductible (30 visits per year)	\$50, no deductible (30 visits per year)	\$50, no deductible (30 visits per year)	20%, after deductible (20 visits per year)	\$50, no deductible (20 visits per year)	\$50, no deductible (20 visits per year)

Hospital/other medical services

Inpatient hospital services	\$500 ¹	\$400 ¹	\$200 ¹	\$100 ¹	20%/unlimited days	30%, after deductible/ unlimited days	30%, after deductible/ unlimited days	30%, after deductible/ unlimited days	20%, after deductible/ unlimited days	20%, after deductible/ unlimited days	20%, after deductible/ unlimited days			
Maternity hospitalization	\$200	\$100	\$100	\$100	Not covered				30%, after deductible	30%, after deductible	30%, after deductible	Not covered	Not covered	Not covered
Emergency room (not waived if admitted)					20%							20%, after deductible	20%, after deductible	
Outpatient surgery	\$500	\$400	\$200	\$0	20%	30%, after deductible	30%, after deductible	30%, after deductible	20%, after deductible	20%, after deductible	20%, after deductible			
Ambulance	\$0	\$0	\$0	\$0		\$0, no deductible	\$0, no deductible	\$0, no deductible	20%, after deductible					
Outpatient lab/pathology						\$50, no deductible	\$50, no deductible	\$50, no deductible	20%, after deductible			20%, after deductible	20%, after deductible	
Routine radiology/diagnostic	\$50	\$30	\$25	\$20		\$100, no deductible	\$100, no deductible	\$100, no deductible						
MRI/MRA, CT/CTA scan, PET scan	\$100	\$60	\$50	\$40		50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible					
Biotech/specialty injectables	\$125	\$100	\$75	\$50										
Durable medical equipment	50%	50%	50%	50%		Not covered	Not covered	Not covered	Not covered			Not covered	Not covered	Not covered
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered	Not covered	Not covered	Not covered	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	None	None	None	None	None
Generic formulary copay	\$10, after prescription deductible	\$10, after prescription deductible	\$10, after prescription deductible	\$10, after prescription deductible	\$10	\$10	\$10	\$10	\$10 copay, no deductible	\$10	\$10
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	35% coinsurance, \$250 maximum copay	35% coinsurance, \$250 maximum copay	35% coinsurance, \$250 maximum copay	Not covered	35% coinsurance, \$250 maximum copay	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	45% coinsurance, \$250 maximum copay	45% coinsurance, \$250 maximum copay	45% coinsurance, \$250 maximum copay		45% coinsurance, \$250 maximum copay	45% coinsurance, \$250 maximum copay
Prescription mail order	Available	Available	Available	Available	Available	Available	Available	Available	Available for generic formulary only	Available	Available
Maximum prescription drug benefit, individual/family	None	None	None	None	None	None	None	None	None	None	None

¹ For PPO plans, maximums shown are combined for in- and out-of-network care.

² Paid-in-full benefit available with select group of frames at Davis Vision participating providers.

³ Amount shown reflects the copayment per day. There is a maximum of five copayments per admission.

Questions? Contact your broker.