

What's not covered?

- services not medically necessary;
- 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;
- expenses related to organ donation for nonmember recipients;
- dental care, including dental implants or dentures, and nonsurgical treatment of temporomandibular joint syndrome (TMJ);
- music therapy, equestrian therapy, and hippotherapy;
- treatment of sexual dysfunction not related to organic disease, except for sexual dysfunction relating to an injury;
- routine foot care, unless medically necessary or associated with the treatment of diabetes;
- foot orthotics, except for orthotics and podiatric appliances required for the prevention of complications associated with diabetes;
- cranial prosthesis including wigs intended to replace hair;
- alternative therapies/complementary medicine, such as acupuncture;
- routine physical exams for nonpreventive purposes, such as insurance or employment applications, college, or premarital examinations;
- 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 (HMO plans only).

Note: Eligible dependent children are covered to age 26.

This summary represents only a partial listing of benefits and exclusions of the Keystone Health Plan East and Personal Choice® programs. These managed care plans may not cover all of your health care expenses. Read your contract, member handbook, and/or benefit booklet carefully to determine which health care services are covered. If you need more information, please call 1-800-ASK-BLUE (1-800-275-2583).



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FOR SMALL EMPLOYERS

Copay plans



HMO products underwritten and administered by Keystone Health Plan East and QCC Insurance Company. 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

Benefits per contract year	You pay				You pay in-network				You pay out-of-network*	
	HMO 1 and 1.1	HMO 2 and 2.1	HMO 3 and 3.1	HMO 5 and 5.1	Direct POS 1 and 1.1	Direct POS 2 and 2.1	Direct POS 3 and 3.1	Direct POS 5 and 5.1	Direct POS 1, 1.1, 2, 2.1, 3, and 3.1	Direct POS 5 and 5.1
Deductible, individual/family	None				None				\$500/\$1,500	\$1,500/\$4,500
Coinsurance	None				None				30%	50%
Out-of-pocket maximum, individual/family (includes coinsurance)	None				None				\$3,000/\$9,000	\$10,000/\$30,000
Lifetime maximum	Unlimited				Unlimited				Unlimited	

Preventive services

Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	\$0				\$0				30%, no deductible	50%, no deductible
Nutrition counseling (6 visits per contract year)	\$0				\$0				30%, after deductible	50%, after deductible

Physician services

Primary care office visit	\$10	\$15	\$20	\$30	\$10	\$15	\$20	\$30	30%, after deductible	50%, after deductible
Specialist office visit	\$20	\$30	\$40	\$50	\$20	\$30	\$40	\$50		
Routine eye care (once every two calendar years)	\$0				\$0				Not covered	
Eyeglasses or contacts (once every two calendar years)	\$100 benefit				\$100 benefit				Up to \$100 reimbursement	
Spinal manipulations (20 visits per contract year)	\$20	\$30	\$40	\$50	\$20 ¹	\$30 ¹	\$40 ¹	\$50 ¹	30%, after deductible	50%, after deductible
Physical/occupational therapy (30 visits per contract year)										

Hospital/other medical services

Inpatient hospital services/days (including maternity)	\$0/unlimited days	\$100/day, max 5 copays/admission; unlimited days	\$250/day, max 5 copays/admission; unlimited days	\$400/day, max 5 copays/admission; unlimited days	\$0/unlimited days	\$100/day, max 5 copays/admission; unlimited days	\$250/day, max 5 copays/admission; unlimited days	\$400/day, max 5 copays/admission; unlimited days	30%, after deductible/70 days	50%, after deductible/70 days
Emergency room (not waived if admitted)	\$100		\$125	\$400	\$100		\$125	\$400	Covered at the in-network level	
Outpatient surgery	\$0	\$100	\$250	\$400	\$0	\$100	\$250	\$400	30%, after deductible	50%, after deductible
Outpatient lab/pathology	\$0				\$0 ¹					
Routine radiology/diagnostic	\$20	\$30	\$40	\$50	\$20 ¹	\$30 ¹	\$40 ¹	\$50 ¹		
MRI/MRA, CT/CTA scan, PET scan	\$40	\$60	\$80	\$100	\$40	\$60	\$80	\$100		
Biotech/specialty injectables	\$50	\$75	\$100	\$125	\$50	\$75	\$100	\$125	50%, after deductible	
Durable medical equipment/prosthetics	50%				50%					
Outpatient mental health care (20 visits/contract year)	\$20	\$30	\$40	\$50	\$20	\$30	\$40	\$50	30%, after deductible, up to 20 days per contract year	50%, after deductible, up to 20 days per contract year
Inpatient mental health care (30 days/contract year)	\$0	\$100/day, max 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max 5 copays/admission	\$0	\$100/day, max of 5 copays/admission	\$250/day, max of 5 copays/admission	\$400/day, max of 5 copays/admission		
Outpatient serious mental illness care (60 visits/contract year)	\$20	\$30	\$40	\$50	\$20	\$30	\$40	\$50	50%, after deductible	
Inpatient serious mental illness care (30 days/contract year)	\$0	\$100/day, max 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max 5 copays/admission	\$0	\$100/day, max 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max 5 copays/admission	30%, after deductible	50%, after deductible
Substance abuse treatment										
Detox (7 days per admission/4 admissions lifetime max)	\$0	\$100/day, max 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max 5 copays/admission	\$0	\$100/day, max of 5 copays/admission	\$250/day, max of 5 copays/admission	\$400/day, max of 5 copays/admission	30%, after deductible	50%, after deductible
Rehabilitation (30 days per contract year/90 days lifetime max)										
Outpatient (60 visits per contract year/120 visits lifetime max)										

Prescription drug

Plan name	HMO 1	HMO 1.1	HMO 2	HMO 2.1	HMO 3	HMO 3.1	HMO 5	HMO 5.1	DPOS 1	DPOS 1.1	DPOS 2	DPOS 2.1	DPOS 3	DPOS 3.1	DPOS 5	DPOS 5.1	All Direct POS plans
Prescription deductible, individual/family	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None	None
Generic formulary copay	\$10	\$10	\$10	\$10	\$7	\$10	\$7	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$7	\$10	30% of total retail cost reimbursed
Brand formulary copay	\$20	\$40	\$20	\$40	50% up to \$125 max per prescription	\$45	50% up to \$125 max per prescription	\$45	\$20	\$40	\$20	\$40	\$20	\$40	50% up to \$125 max per prescription	\$45	
Non-formulary copay	\$35	\$70	\$35	\$70	50% up to \$125 max per prescription	\$75	50% up to \$125 max per prescription	\$75	\$35	\$70	\$35	\$70	\$35	\$70	50% up to \$125 max per prescription	\$75	
Prescription mail order	Included		Included		Included		Included		Included		Included		Included		Included		Not available

Groups may not offer identical medical plans, for example HMO 1 and HMO 1.1.

¹Referral required from primary care physician

*To receive maximum benefits, services must be provided by a Keystone Health Plan East participating provider. This is a highlight of benefits available. The benefits and exclusions for in-network and out-of-network care are not the same. All benefits are provided in accordance with the HMO group contract and out-of-network benefit booklet/certificate.

Questions? Contact your broker, call IBC at 215-241-3400, or visit www.ibx.com/bluesolutions.

Continued

Copay plans, continued

Benefits per contract year	You pay in-network						You pay out-of-network*			
	Personal Choice PPO 1 and 1.1	Personal Choice PPO 2 and 2.1	Personal Choice PPO 3 and 3.1	Personal Choice PPO 4 and 4.1	Personal Choice PPO 5 and 5.1	Personal Choice PPO 6 and 6.1	Personal Choice PPO 1, 1.1, 2, 2.1, 3, and 3.1	Personal Choice PPO 4 and 4.1	Personal Choice PPO 5 and 5.1	Personal Choice PPO 6 and 6.1
Deductible, individual/family	None						\$500/\$1,500	\$1,500/\$4,500	\$3,000/\$9,000	\$6,000/\$12,000
Coinsurance							30%	50%		
Out-of-pocket maximum, individual/family (includes coinsurance only)							\$3,000/\$9,000	\$10,000/\$30,000	\$15,000/\$45,000	\$18,000/\$36,000
Lifetime maximum	Unlimited						Unlimited			

Preventive services

Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	\$0						30%, no deductible	50%, no deductible		
Nutrition counseling (6 visits per contract year ¹)							30%, after deductible	50%, after deductible		

Physician services

Primary care office visit	\$10	\$15	\$20	\$30	\$30	\$40	30%, after deductible	50%, after deductible		
Specialist office visit	\$20	\$30	\$40	\$50	\$50	\$75				
Routine eye care (once every two calendar years ¹)	\$0						Up to \$35 reimbursement			
Eyeglasses or contacts (once every two calendar years ¹)	\$100 benefit						Up to \$100 reimbursement			
Spinal manipulations (20 visits per contract year ¹)	\$20	\$30	\$40	\$50	\$50	\$75	30%, after deductible	50%, after deductible		
Physical/occupational therapy (30 visits per contract year ¹)										

Hospital/other medical services

Inpatient hospital services/days (including maternity) ¹	\$0/unlimited days	\$100/day, max 5 copays/admission; unlimited days	\$250/day, max 5 copays/admission; unlimited days	\$400/day, max 5 copays/admission; unlimited days	\$600/day, max 5 copays/admission; unlimited days	\$750/day, max 5 copays/admission; unlimited days	30%, after deductible/70 days	50%, after deductible/70 days						
Emergency room (not waived if admitted)	\$100						\$125	\$150						
Outpatient surgery	\$0	\$100	\$250	\$400	\$600	\$750	30%, after deductible	50%, after deductible						
Outpatient lab/pathology	\$0										\$0			
Routine radiology/diagnostic	\$20	\$30	\$40	\$50	\$50	\$75								
MRI/MRA, CT/CTA scan, PET scan	\$175										\$175			
Biotech/specialty injectables	\$50	\$75	\$100	\$125	\$125									
Durable medical equipment/prosthetics	30%		50%			50%		50%, after deductible						
Outpatient mental health care (20 visits/contract year ¹)	\$20	\$30	\$40	\$50	\$50	\$75	30%, after deductible/20 days per contract year	50%, after deductible, 20 days per contract year						
Inpatient mental health care (30 days/contract year ¹)	\$0	\$100/day, max of 5 copays/admission	\$250/day, max of 5 copays/admission	\$400/day, max of 5 copays/admission	\$600/day, max of 5 copays/admission	\$750/day, max of 5 copays/admission								
Outpatient serious mental illness care (60 visits/contract year ¹)	\$20	\$30	\$40	\$50	\$50	\$75	50%, after deductible	50%, after deductible						
Inpatient serious mental illness care (30 days/contract year ¹)	\$0	\$100/day, max 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max of 5 copays/admission	\$600/day, max of 5 copays/admission	\$750/day, max of 5 copays/admission	30%, after deductible							
Substance abuse treatment														
Detox (7 days per admission/4 admissions lifetime maximum ¹)	\$0	\$100/day, max of 5 copays/admission	\$250/day, max 5 copays/admission	\$400/day, max 5 copays/admission	\$600/day, max 5 copays/admission	\$750/day, max 5 copays/admission	30%, after deductible	50%, after deductible						
Rehabilitation (30 days per contract year/90 days lifetime maximum ¹)														
Outpatient (60 visits per contract year/120 visits lifetime maximum ¹)	\$20	\$30	\$40	\$50	\$50	\$75								

Prescription drug

Plan name	PPO 1	PPO 1.1	PPO 2	PPO 2.1	PPO 3	PPO 3.1	PPO 4	PPO 4.1	PPO 5	PPO 5.1	PPO 6	PPO 6.1	PPO 1, 1.1, 2, 2.1, 3, and 3.1	PPO 4, 4.1, 5, 5.1, 6, and 6.1
Prescription deductible, individual/family	None	None	None	None	None	None	None	None	None	None	None	None	None	None
Generic formulary copay	\$10	\$10	\$10	\$10	\$10	\$10	\$7	\$10	\$7	\$10	\$7	\$10	30% of total retail cost reimbursed	30% of total retail cost reimbursed
Brand formulary copay	\$20	\$40	\$20	\$40	\$20	\$40	50% up to \$125 max per prescription	\$45	50% up to \$125 max per prescription	\$45	50% up to \$125 max per prescription	\$45		
Non-formulary brand copay	\$35	\$70	\$35	\$70	\$35	\$70	\$75	\$75	\$75	\$75	\$75			
Prescription mail order	Included		Included		Included		Included		Included		Included		Not available	Not available

Groups may not offer identical medical plans, for example PPO 1 and PPO 1.1.

¹Combined in- and out-of-network

*Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Personal Choice, and the actual charge of the provider. This amount may be significant. Claims payments for Non-Preferred Professional Providers (physicians) are based on the lesser of the Medicare Professional Allowable Payment or the actual charge of the provider. For covered services that are not recognized or reimbursed by Medicare, the payment is based on the lesser of the Independence Blue Cross (IBC) applicable proprietary fee schedule or the actual charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, payment is 50% of the actual charge of the provider. For services rendered by hospitals and other facility providers in the local service area, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with 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. It is important to note that all percentages for out-of-network services are percentages of the Plan allowance, not the actual charge of the provider.

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