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.

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

- maternity care
- routine eye care

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, please call 1-800-263-1410.

Independence Blue Cross®

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

16485 2012-0089 04/12

Individual Coverage Options

Independence Blue Cross®

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, visit ibx4you.com.

Our lowest cost plan!

	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	Personal Choice PPO 5000 HSA	Personal Choice PPO 3000 HSA
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**	**You pay**	**You pay**
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	$5,000/$10,000	$3,000/$6,000
Coinsurance, after deductible					20%, unless otherwise noted	30%, unless otherwise noted	30%, unless otherwise noted	30%, unless otherwise noted	20%, unless otherwise noted	20%, unless otherwise noted	20%, unless otherwise noted	N/A	20%, unless otherwise noted
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	$5,000/$10,000 Includes deductible	$5,000/$10,000 Includes copays 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	$0, no deductible	$0, no deductible
Pediatric immunizations													
Routine gynecological exam/Pap test (no referral required, 1 per year[1])													
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	$0, after deductible	20%, after 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				Not covered	Not covered	Not covered	Not covered	Not covered
Eyeglasses or contact lenses (once every two years)	$35 benefit[2]	$35 benefit[2]	$35 benefit[2]	$35 benefit[2]		$35 benefit[2]	$35 benefit[2]	$35 benefit[2]					
Spinal manipulations[1]	$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, no deductible (20 visits per year)	$50, no deductible (20 visits per year)	$50, no deductible (20 visits per year)	20%, after deductible (20 visits per year)	$50, no deductible (20 visits per year)	$50, no deductible (20 visits per year)	$0, after deductible (20 visits per year)	20%, after deductible (20 visits per year)
Physical/occupational therapy[1]	$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[3]	$400[3]	$200[3]	$100[3]	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	$0, after deductible/ unlimited days	20%, after deductible/ unlimited days
Emergency room (not waived if admitted)	$200	$100	$100	$100	20%				20%, after deductible	20%, after deductible	20%, after deductible	$0, after deductible	20%, after deductible
Outpatient surgery	$500	$400	$200										
Outpatient lab/pathology	$0	$0	$0	$0		$0, no deductible	$0, no deductible	$0, no deductible					
Routine radiology/diagnostic	$50	$30	$25	$20		$50, no deductible	$50, no deductible	$50, no deductible					
MRI/MRA, CT/CTA scan, PET scan	$100	$60	$50	$40		$100, no deductible	$100, no deductible	$100, no deductible					
Prescription drug													
Prescription deductible, individual/family	$400/$1200	$250/$750	$100/$300	$100/$300	None	None	None	None	None	None	None	Integrated with medical	Integrated with medical
Generic formulary	$10[4]	$10[4]	$10[4]	$10[4]	$10	$10	$10	$10	$10	$10	$10	$0, after deductible	$10, after deductible
Brand formulary	30%, $250 maximum copay[4]	30%, $250 maximum copay[4]	30%, $250 maximum copay[4]	30%, $250 maximum copay[4]	35%, $250 maximum copay	35%, $250 maximum copay	35%, $250 maximum copay	35%, $250 maximum copay	Not covered	35%, $250 maximum copay	35%, $250 maximum copay		$30, after deductible
Non-formulary	40%, $250 maximum copay[4]	40%, $250 maximum copay[4]	40%, $250 maximum copay[4]	40%, $250 maximum copay[4]	45%, $250 maximum copay	45%, $250 maximum copay	45%, $250 maximum copay	45%, $250 maximum copay		45%, $250 maximum copay	45%, $250 maximum copay		$50, after deductible
Prescription mail order	Available	Available	Available	Available	Available	Available	Available	Available	Available for generic formulary only	Available	Available	Available	Available

[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. Davis Vision is an independent company that administers the vision program.

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

[4] After prescription deductible