

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).



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

www.ibx.com/bluesolutions

BLUESolutions®
FOR SMALL EMPLOYERS

Deductible plans



Referred benefits are underwritten or administered by Keystone Health Plan East; self-referred benefits are underwritten or administered by QCC Insurance Company, subsidiaries of Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.

Deductible plans

New Rx alternatives with ".1" plans

Benefits per contract year	You pay			You pay in-network					You pay out-of-network
	HMO 4 and 4.1	HMO 6 and 6.1	HMO 7 and 7.1	Direct POS 4 and 4.1	Direct POS 6 and 6.1	Direct POS 7 and 7.1	Personal Choice PPO 7 and 7.1	Personal Choice PPO 8 and 8.1	All Direct POS* plans and Personal Choice PPO+ plans
Deductible, individual/family	\$1,000/\$3,000	\$2,000/\$6,000	\$3,000/\$9,000	\$1,000/\$3,000	\$2,000/\$6,000	\$3,000/\$9,000	\$1,000/\$3,000	\$2,000/\$6,000	\$5,000/\$15,000
Coinsurance	20%		30%	20%		30%	10%	20%	50%
Out-of-pocket maximum, individual/family (includes coinsurance only)	\$3,000/\$9,000		\$5,000/\$15,000	\$3,000/\$9,000		\$5,000/\$15,000	\$3,000/\$9,000		\$15,000/\$45,000
Lifetime maximum	Unlimited			Unlimited			Unlimited		Unlimited

Preventive services

Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	\$0, no deductible	\$0, no deductible	\$0, no deductible	50%, no deductible
Nutrition counseling (6 visits per contract year) ²				50%, after deductible

Physician services

Primary care office visit	\$20, no deductible	\$20, no deductible	\$20, no deductible	\$30, no deductible	50%, after deductible
Specialist office visit	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$50, no deductible	
Routine eye care (once every two calendar years) ²	\$0, no deductible	\$0, no deductible	\$0		Up to \$35 reimbursement
Eyeglasses or contacts (once every two calendar years) ²	\$100 benefit	\$100 benefit	\$100 benefit		Up to \$100 reimbursement
Spinal manipulations (20 visits per contract year) ²	\$40, no deductible	\$40, no deductible ¹	\$40, no deductible	\$50, no deductible	50%, after deductible
Physical/occupational therapy (30 visits per contract year) ²					

Hospital/other medical services

Inpatient hospital services/days (includes maternity) ²	20%, after deductible/unlimited days	30%, after deductible/unlimited days	20%, after deductible/unlimited days	30%, after deductible/unlimited days	10% after deductible/unlimited days	20% after deductible/unlimited days	50%, after deductible/70 days
Emergency room (not waived if admitted)	20%, after deductible	30%, after deductible	20%, after deductible	30%, after deductible	10% after deductible	20% after deductible	Covered at the in-network level
Outpatient surgery							
Outpatient lab/pathology	\$0, no deductible	\$0, no deductible ¹	\$0, no deductible ¹	\$0, no deductible ¹	10% after deductible	20% after deductible	50%, after deductible
Routine radiology/diagnostic	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40, no deductible			
MRI/MRA, CT/CTA scan, PET scan	\$80, no deductible	\$80, no deductible	\$80, no deductible	\$80, no deductible			
Biotech/specialty injectables	\$100, no deductible	\$100, no deductible	\$100, no deductible	\$100, no deductible			
Durable medical equipment/prosthetics	50%, after deductible	50%, after deductible	50%, after deductible	50%, after deductible			
Outpatient mental health care (20 visits/contract year) ²	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40 copay, no deductible	\$50 copay, no deductible	
Inpatient mental health care (30 days/contract year) ²	20%, after deductible	30%, after deductible	20%, after deductible	30%, after deductible	10% after deductible	20% after deductible	50%, after deductible, 20 days per contract year
Outpatient serious mental illness care (60 visits/contract year) ²	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40 copay, no deductible	\$50 copay, no deductible	50%, after deductible
Inpatient serious mental illness care (30 days/contract year) ²	20%, after deductible	30%, after deductible	20%, after deductible	30%, after deductible	10% after deductible	20% after deductible	
Substance abuse treatment							
Detox (7 days per admission/4 admissions lifetime max) ²	20%, after deductible	30%, after deductible	20%, after deductible	30%, after deductible	10% after deductible	20% after deductible	50%, after deductible
Rehabilitation (30 days per contract year/90 days lifetime max) ²							
Outpatient (60 visits per contract year/120 visits lifetime max) ²	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40, no deductible	\$40 copay, no deductible	\$50 copay, no deductible	

Prescription drug

Plan name	HMO 4	HMO 4.1	HMO 6	HMO 6.1	HMO 7	HMO 7.1	DPOS 4	DPOS 4.1	DPOS 6	DPOS 6.1	DPOS 7	DPOS 7.1	PPO 7	PPO 7.1	PPO 8	PPO 8.1	All DPOS and PPO Plans
Prescription deductible, individual/family	None	None	\$250	\$250 ³	\$250	None	None	None	\$250	\$250 ³	\$250	None	None	\$250 ³	None	\$250 ³	None
Generic formulary copay	\$7	\$10	\$20	\$10, no deductible	\$20	\$4	\$7	\$10	\$20	\$10, no deductible	\$20	\$4	\$10	\$10, no deductible	\$10	\$10	30% of total retail cost reimbursed
Brand formulary copay	50% up to \$125 max per prescription	\$45	\$40	\$45	\$40	Discount available ⁴	50% up to \$125 max per prescription	\$45	\$40	\$45	\$40	Discount available ⁴	\$45	\$45	\$45	\$45	
Non-formulary brand copay		\$75	\$60	\$75	\$60		\$75	\$60	\$75	\$60	\$75		\$75	\$75	\$75		
Prescription mail order	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Included	Not available

Groups may not offer identical medical plans, for example HMO 4 and HMO 4.1.

¹Referral required from primary care physician

²Combined in- and out-of-network PPO plans only

³Deductible waived on generic drugs

⁴Brand drugs vary in cost, and cost sharing is based on a discounted amount that was negotiated with the pharmacy.

*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.

*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 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.