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

2011-0241 Plus Deductible 2/12

Deductible plans

Deductible plans

	With a referral, you pay			Without a referral, you pay*	You pay in-network			You pay out-of-network*
Benefits per calendar year	**POS Plus 5A**	**POS Plus 6A**	**POS Plus 7A**	**All POS Plus deductible plans**	**DPOS Plus 4A**	**DPOS Plus 5A**	**DPOS Plus 6A**	**All DPOS Plus deductible plans**
Deductible, individual/family	$1,000/$3,000	$2,000/$6,000	$3,000/$9,000	$5,000/$15,000	$1,000/$3,000	$2,000/$6,000	$3,000/$9,000	$5,000/$15,000
Coinsurance	20%, after deductible		30%, after deductible	50%, after deductible	20%, after deductible	20%, after deductible	30%, after deductible	50%, after deductible
Out-of-pocket maximum, individual/family (includes coinsurance only)	$3,000/$9,000		$5,000/$15,000	$30,000/$90,000	$3,000/$9,000	$3,000/$9,000	$5,000/$15,000	$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			50%, no deductible	$0, no deductible			50%, no deductible
Nutrition counseling (6 visits per calendar year)				50%, after deductible				50%, after deductible
Physician services								
Primary care office visit	$20, no deductible	$40, no deductible	$20, no deductible	50%, after deductible	$20, no deductible	$40, no deductible	$20, no deductible	50%, after deductible
Specialist office visit	$40, no deductible	$50, no deductible	$40, no deductible		$40, no deductible	$50, no deductible	$40, no deductible	
Routine eye care (once every two calendar years)				Not covered	$40, no deductible[1]	$50, no deductible[1]	$40, no deductible[1]	Not Covered
Spinal manipulations (20 visits per year)				50%, after deductible				50%, after deductible
Physical/occupational therapy (30 visits per calendar year)								
Hospital/other medical services								
Inpatient hospital services/days	20%, after deductible/unlimited days		30%, after deductible/ unlimited days	50%, after deductible/ 70 days[2]	20%, after deductible/ unlimited days		30%, after deductible/ unlimited days	50%, after deductible/ 70 days[2]
Emergency room (not waived if admitted)	20%, after deductible		30%, after deductible	Covered at the in-network level	20%, after deductible		30%, after deductible	Covered at the in-network level
Maternity hospitalization				50%, after deductible				50%, after deductible
Outpatient surgery								
Ambulance (emergency)				Covered at the in-network level				Covered at the in-network level
Outpatient lab/pathology	$0, no deductible			50%, after deductible	$0, no deductible			50%, after deductible
Routine radiology/diagnostic	$40, no deductible	$50, no deductible	$40, no deductible		$40, no deductible[1]	$50, no deductible[1]	$40, no deductible[1]	
MRI/MRA, CT/CTA scan, PET scan	$80, no deductible	$100, no deductible	$80, no deductible		$80, no deductible[1]	$100, no deductible[1]	$80, no deductible[1]	
Biotech/specialty injectables	$100, no deductible	$125, no deductible	$100, no deductible		$100, no deductible	$125, no deductible	$100, no deductible	
Durable medical equipment/prosthetics	50%, after deductible				50%, after deductible			
Outpatient mental health care	$40, no deductible	$50, no deductible	$40, no deductible		$40, no deductible	$50, no deductible	$40, no deductible	
Inpatient mental health care[2]	20%, after deductible		30%, after deductible		20%, after deductible		30%, after deductible	
Outpatient serious mental illness care	$40, no deductible	$50, no deductible	$40, no deductible		$40, no deductible	$50, no deductible	$40, no deductible	
Inpatient serious mental illness care[2]	20%, after deductible		30%, after deductible		20%, after deductible		30%, after deductible	
Substance abuse treatment								
Detox[2]	20%, after deductible		30%, after deductible	50%, after deductible	20%, after deductible		30%, after deductible	50%, after deductible
Rehabilitation[2]								
Outpatient	$40, no deductible	$50, no deductible	$40, no deductible		$40, no deductible	$50, no deductible	$40, no deductible	

[1]Referral required from primary care physician.

[2]Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental health, substance abuse, and detoxification services.

*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/bluesolutionsplus.

Continued

Deductible plans, continued

Benefits per calendar year	You pay in-network: PPO Plus 5A	PPO Plus 6A	PPO Plus 7A	PPO Plus 8A	PPO Plus 9A	PPO Plus 10A	You pay out-of-network*: PPO Plus 5A	PPO Plus 6A	PPO Plus 7A	PPO Plus 8A	PPO Plus 9A	PPO Plus 10A
Deductible, individual/family	$1,000/$3,000	$2,000/$4,000	$2,000/$6,000	$2,500/$5,000[4]	$3,000/$6,000[4]	$4,000/$8,000[4]	$5,000/$15,000	$5,000/$10,000	$5,000/$15,000	$5,000/$10,000	$6,000/$12,000	
Coinsurance	20%, after deductible	$0, after deductible	20%, after deductible	$0, after deductible	10%, after deductible	10%, after deductible	50%, after deductible					
Out-of-pocket maximum, individual/family (includes coinsurance only)[6]	$3,000/$9,000	$5,000/$10,000	$3,000/$9,000	$5,000/$10,000		$5,000/$10,000	$15,000/$45,000	$10,000/$20,000	$15,000/$45,000	$10,000/$20,000		
Lifetime maximum	Unlimited						Unlimited					
Preventive services												
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0, no deductible						50%, no deductible					
Nutrition counseling (6 visits per calendar year)							50%, after deductible					
Physician services												
Primary care office visit	$20, no deductible	$35, no deductible	$20, no deductible	$30, after deductible	$40, after deductible	$40, after deductible	50%, after deductible					
Specialist office visit	$40, no deductible	$60, no deductible	$40, no deductible	$50, after deductible	$60, after deductible	$60, after deductible						
Spinal manipulations (20 visits per year[1])	$40, no deductible	$60, no deductible	$40, no deductible	$50, after deductible	$60, after deductible	$60, after deductible	50%, after deductible					
Physical/occupational therapy (30 visits per calendar year[1])												
Hospital/other medical services												
Inpatient hospital services/days	20%, after deductible/ unlimited days	$0, after deductible/ unlimited days	20%, after deductible/ unlimited days	$500/day, after deductible/ unlimited days[3]	10%, after deductible/ unlimited days	10%, after deductible/ unlimited days	50%, after deductible/ 70 days					
Emergency room (not waived if admitted)	20%, after deductible	$0, after deductible	20%, after deductible	$200, after deductible[5]	$200, after deductible[5]	$200, after deductible[5]	Covered at the in-network level					
Maternity hospitalization				$500/day, after deductible[3]	10%, after deductible	10%, after deductible	50%, after deductible					
Outpatient surgery				$500, after deductible								
Ambulance (emergency)				$0, no deductible		$0, no deductible	Covered at the in-network level					
Outpatient lab/pathology				$60, after deductible	$70, after deductible	$70, after deductible	50%, after deductible					
Routine radiology/diagnostic		$60, no deductible		$60, after deductible								
MRI/MRA, CT/CTA scan, PET scan		$200, no deductible		$200, after deductible		$200, after deductible						
Biotech/specialty injectables	$100, no deductible	$50, no deductible	$100, no deductible	$100, after deductible	$150, after deductible	$150, after deductible						
Durable medical equipment/prosthetics	50%, after deductible					50%, after deductible						
Outpatient mental health care	$40, no deductible	$60, no deductible	$40, no deductible	$50, after deductible	$60, after deductible	$60, after deductible						
Inpatient mental health care[2]	20%, after deductible	$0, after deductible	20%, after deductible	$500/day, after deductible[3]	10%, after deductible	10%, after deductible						
Outpatient serious mental illness care	$40, no deductible	$60, no deductible	$40, no deductible	$50, after deductible	$60, after deductible	$60, after deductible						
Inpatient serious mental illness care[2]	20%, after deductible	$0, after deductible	20%, after deductible	$500/day, after deductible[3]	10%, after deductible	10%, after deductible						
Substance abuse treatment												
Detox[2]	20%, after deductible	$0, after deductible	20%, after deductible	$500/day, after deductible[3]	10%, after deductible	10%, after deductible	50%, after deductible					
Rehabilitation[1]												
Outpatient	$40, no deductible	$60, no deductible	$40, no deductible	$50, after deductible	$60, after deductible	$60, after deductible						
Prescription drug												
Prescription deductible, individual/family	Add prescription benefits, see page 17			Integrated with medical			Add prescription benefits, see page 17			Integrated with medical		
Generic formulary copay				$20, after deductible						50%, after deductible		
Brand formulary copay				$40, after deductible						50%, after deductible		
Non-formulary copay				$70, after deductible						50%, after deductible		
Prescription mail order				Available						Not available		

[1]Combined in- and out-of-network.

[2]Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental health, substance abuse, and detoxification services.

[3]Maximum of 5 copays per admission.

[4]Includes aggregate deductible comprising of all prescription drug and medical expenses.

[5]Copay waived if admitted.

[6]For plans 8A, 9A, and 10A, both coinsurance and deductible are included.

*It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. 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.