

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

Personal Choice® HSA plans



HSA plans

Benefits per contract year	You pay in-network					You pay out-of-network*
	Personal Choice HDHP 1	Personal Choice HDHP 2	Personal Choice HDHP 3	Personal Choice HDHP 4	Personal Choice HDHP 5	All Personal Choice HDHPs
Deductible, individual/family	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$3,000/\$6,000	\$5,000/\$10,000
Coinsurance, after deductible	\$0, after deductible				20%, after deductible	50%, after deductible
Out-of-pocket maximum, individual/family (includes deductibles, copays, and coinsurance)	\$5,600/\$11,200					\$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 contract year ¹)		50%, after deductible

Physician services

Primary care office visit (includes maternity)	\$0, after deductible	20%, after deductible	50%, after deductible
Specialist office visit			
Routine eye care (once every two calendar years ¹)	\$0, no deductible		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)	\$0, after deductible	20%, after deductible	50%, after deductible
Physical/occupational therapy (30 visits per contract year ¹)			

Hospital/other medical services

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

Prescription drug

Prescription deductible, individual/family	Integrated with medical	Integrated with medical	Integrated with medical	Integrated with medical	Integrated with medical	Integrated with medical
Generic formulary copay	\$20, after deductible	\$20, after deductible	\$20, after deductible	\$20, after deductible	\$20, after deductible	50%, after deductible
Brand formulary copay	\$40, after deductible	\$40, after deductible	\$40, after deductible	\$40, after deductible	\$40, after deductible	
Non-formulary brand copay	\$60, after deductible	\$60, after deductible	\$60, after deductible	\$60, after deductible	\$60, after deductible	
Prescription mail order	Included	Included	Included	Included	Included	Not available

Note: Prior to benefits being paid, the entire deductible must be met.

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.

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