

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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Benefits underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross —independent licensees of the Blue Cross and Blue Shield Association.



Personal Choice® HSA plans



HSA plans

	You pay in-network					You pay out-of-network*
Benefits per contract year	HDHP Plus 1A	HDHP Plus 2A	HDHP Plus 3A	HDHP Plus 4A	HDHP Plus 5A	All Personal Choice HDHPs
Deductible, individual/family	\$1,500/\$3,000	\$2,000/\$4,000	\$2,500/\$5,000	\$3,000/\$6,000	\$4,500/\$9,000	\$5,000/\$10,000
Coinsurance, after deductible	\$0, after deductible		\$0, after deductible			50%, after deductible
Out-of-pocket maximum, individual/family (includes deductibles, copays, and coinsurance)	\$5,600/\$11,200		\$5,600/\$11,200			\$10,000/\$20,000
Lifetime maximum	Unlimited		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						50%, after deductible
Specialist office visit						
Spinal manipulations (20 visits per contract year ¹)	\$0, after deductible		\$0, after deductible			
Physical/occupational therapy (30 visits per contract year ¹)						

Hospital/other medical services

Inpatient hospital services/days ²	\$0, after deductible/unlimited days		\$0, after deductible/unlimited days			50%, after deductible/70 days ²
Emergency room (not waived if admitted)						Covered at the in-network level
Maternity hospitalization	\$0, after deductible		\$0, after deductible			50%, after deductible
Outpatient surgery						Covered at the in-network level
Ambulance (emergency)						
Outpatient lab/pathology						50%, after deductible
Routine radiology/diagnostic						
MRI/MRA, CT/CTA scan, PET scan						
Biotech/specialty injectables						
Durable medical equipment/prosthetics						
Outpatient mental health care						
Inpatient mental health care ²	\$0, after deductible		\$0, after deductible			
Outpatient serious mental illness care						
Inpatient serious mental illness care ²						
Substance abuse treatment						
Detox ²						
Rehabilitation ²						
Outpatient						

Prescription drug

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

¹Combined in- and out-of-network

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

*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/bluesolutionsplus.