

Copay plans

	HMO 20 Copay	HMO 15 Copay	HMO 10 Copay	Personal Choice PPO 30 Copay	
Benefits per calendar year	You pay	You pay	You pay	You pay in-network	You pay out-of-network**
Deductible, individual/family	None	None	None	None	\$5,000/\$10,000
Coinsurance, after deductible				20%	50%
Out-of-pocket maximum, individual/family				\$5,000/\$10,000 Includes coinsurance only	\$10,000/\$20,000 Includes coinsurance only

Preventive services

Mammogram (no referral required)	\$0	\$0	\$0	\$0	50%, no deductible
Pediatric immunizations (subject to office visit copay)				\$0	
Nutrition counseling (6 visits per year†)				\$0	50%, after deductible

Physician services

Primary care office visit	\$20	\$15	\$10	\$30	50%, after deductible
Specialist office visit	\$30	\$25	\$20	\$50	
Routine gynecological exam/Pap test (no referral required, 1 per year)				\$30	50%, no deductible
Routine eye exam (once every two years)				Not covered	Not covered
Eyeglasses or contact lenses (once every two years)	\$35 benefit*	\$35 benefit*	\$35 benefit*	Not covered	Not covered
Spinal manipulations (20 visits per year†)	\$30	\$25	\$20	\$50	50%, after deductible
Physical/occupational therapy (30 visits per year†)				\$50	

Hospital/other medical services

Inpatient hospital services	\$400 [†]	\$200 [†]	\$100 [†]	20%/unlimited days	50%, after deductible/70 days
Maternity hospitalization				Not covered	Not covered
Emergency room (not waived if admitted)	\$100	\$100	\$100	20%	20%, after in-network deductible
Outpatient surgery	\$400	\$200	20%	50%, after deductible	
Ambulance	\$0	\$0			
Outpatient lab/pathology	\$30	\$25			
Routine radiology/diagnostic					\$20
MRI/MRA, CT/CTA scan, PET scan	\$60	\$50			\$40
Biotech/specialty injectables	\$100	\$75			\$50
Durable medical equipment (HMO: up to \$1,000 per year; PC: up to \$2,000 per year, which includes up to \$1,000 for diabetic equipment and supplies)	50%	50%			50%
Mental health/substance abuse/serious mental illness treatment	Not covered	Not covered			Not covered

Prescription drug

Prescription deductible, individual/family	\$250/\$750	\$100/\$300	\$100/\$300	None	None
Generic formulary copay	\$15, after prescription deductible	\$15, after prescription deductible	\$15, after prescription deductible	\$10	50%, no deductible
Brand formulary copay	\$25, after prescription deductible	\$25, after prescription deductible	\$25, after prescription deductible	\$30	
Non-formulary copay	\$35, after prescription deductible	\$35, after prescription deductible	\$35, after prescription deductible	\$50	
Prescription mail order	Available	Available	Available	Available	Available
Maximum prescription drug benefit, individual/family	Up to \$2,500/\$5,000 per year	Up to \$2,500/\$5,000 per year	Up to \$2,500/\$5,000 per year	Up to \$2,500 per person per year †	

*Paid-in-full benefit available with select group of frames at Davis Vision participating providers.

** It is important to note that all percentages are percentages of the plan allowance, not the provider's actual charge. Out-of-network, non-participating providers may bill you for differences between the plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on Independence Blue Cross's (IBC's) own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with providers, 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.

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

‡ For PPO plans, maximums shown are combined for in- and out-of-network care.

Certain plan benefits may be enhanced in order to comply with health care reform legislation.

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;
- 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. 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

NOTE: Eligible unmarried dependent children are generally covered to age 19 or age 23 (if full-time student). See contract for additional details.

Benefits summary for individuals and families

Copay plans



HMO products underwritten and administered by Keystone Health Plan East.
Personal Choice PPO products underwritten and administered by QCC Insurance Company. Subsidiaries of
Independence Blue Cross – independent licensees of the Blue Cross and Blue Shield Association.