Deductible plans

<table>
<tr><th></th><th>HMO 5000</th><th>HMO 2500</th><th>HMO 1500</th><th colspan="2">Personal Choice PPO 5000</th><th colspan="2">Personal Choice PPO 2500</th></tr>
<tr><th>Benefits per calendar year</th><th>You pay</th><th>You pay</th><th>You pay</th><th>You pay in-network</th><th>You pay out-of-network*</th><th>You pay in-network</th><th>You pay out-of-network*</th></tr>
<tr><td>Deductible, individual/family</td><td>$5,000/$10,000</td><td>$2,500/$5,000</td><td>$1,500/$3,000</td><td>$5,000/$10,000</td><td>$10,000/$20,000</td><td>$2,500/$5,000</td><td>$5,000/$10,000</td></tr>
<tr><td>Coinsurance, after deductible</td><td>30%, unless otherwise noted</td><td>30%, unless otherwise noted</td><td>30%, unless otherwise noted</td><td>20%</td><td>50%</td><td>20%</td><td>50%</td></tr>
<tr><td>Out-of-pocket maximum, individual/family</td><td>$7,500/$15,000</td><td>$5,000/$10,000</td><td>$5,000/$10,000</td><td>$10,000/$20,000</td><td>$20,000/$40,000</td><td>$5,000/$10,000
Includes coinsurance only</td><td>$10,000/$20,000
Includes coinsurance only</td></tr>
<tr><th colspan="8">Preventive services</th></tr>
<tr><td>Mammogram (no referral required)</td><td rowspan="3">$0, no deductible</td><td rowspan="3">$0, no deductible</td><td rowspan="3">$0, no deductible</td><td rowspan="2">$0, no deductible</td><td rowspan="2">50%, no deductible</td><td rowspan="2">$0, no deductible</td><td rowspan="2">50%, no deductible</td></tr>
<tr><td>Pediatric immunizations (subject to office visit copay)</td></tr>
<tr><td>Nutrition counseling (6 visits per year[†])</td><td>$0, no deductible</td><td>50%, after deductible</td><td>$0, no deductible</td><td>50%, after deductible</td></tr>
<tr><th colspan="8">Physician services</th></tr>
<tr><td>Primary care office visit</td><td>$30, no deductible</td><td>$30, no deductible</td><td>$30, no deductible</td><td>$30, no deductible</td><td rowspan="2">50%, after deductible</td><td>$30, no deductible</td><td rowspan="2">50%, after deductible</td></tr>
<tr><td>Specialist office visit</td><td>$50, no deductible</td><td>$50, no deductible</td><td>$50, no deductible</td><td>$50, no deductible</td><td>$50, no deductible</td></tr>
<tr><td>Routine gynecological exam/Pap test (no referral required, 1 per year)</td><td>$30, no deductible</td><td>$30, no deductible</td><td>$30, no deductible</td><td>$30, no deductible</td><td>50%, no deductible</td><td>$30, no deductible</td><td>50%, no deductible</td></tr>
<tr><td>Routine eye exam (once every two years)</td><td>$50, no deductible</td><td>$50, no deductible</td><td>$50, no deductible</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Eyeglasses or contact lenses (once every two years)</td><td>$35 benefit*</td><td>$35 benefit*</td><td>$35 benefit*</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Spinal manipulations (20 visits per year[†])</td><td rowspan="2">$50, no deductible</td><td rowspan="2">$50, no deductible</td><td rowspan="2">$50, no deductible</td><td rowspan="2">$50, no deductible</td><td rowspan="2">50%, after deductible</td><td rowspan="2">$50, no deductible</td><td rowspan="2">50%, after deductible</td></tr>
<tr><td>Physical/occupational therapy (30 visits per year[†])</td></tr>
<tr><th colspan="8">Hospital/other medical services</th></tr>
<tr><td>Inpatient hospital services/days</td><td rowspan="5">30%, after deductible/unlimited</td><td rowspan="5">30%, after deductible/unlimited</td><td rowspan="5">30%, after deductible/unlimited</td><td>20%, after deductible/unlimited</td><td>50%, after deductible/70</td><td>20%, after deductible/unlimited</td><td>50%, after deductible/70</td></tr>
<tr><td>Maternity hospitalization</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><td>Emergency room (not waived if admitted)</td><td>20%, after deductible</td><td>20%, after in-network deductible</td><td>20%, after deductible</td><td>20%, after in-network deductible</td></tr>
<tr><td>Outpatient surgery</td><td rowspan="7">20%, after deductible</td><td rowspan="7">50%, after deductible</td><td rowspan="7">20%, after deductible</td><td rowspan="7">50%, after deductible</td></tr>
<tr><td>Ambulance</td></tr>
<tr><td>Outpatient lab/pathology</td><td>$0, no deductible</td><td>$0, no deductible</td><td>$0, no deductible</td></tr>
<tr><td>Routine radiology/diagnostic</td><td>$50, no deductible</td><td>$50, no deductible</td><td>$50, no deductible</td></tr>
<tr><td>MRI/MRA, CT/CTA scan, PET scan</td><td rowspan="2">$100, no deductible</td><td rowspan="2">$100, no deductible</td><td rowspan="2">$100, no deductible</td></tr>
<tr><td>Biotech/specialty injectables</td></tr>
<tr><td>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 equiptment and supplies)</td><td>50%, after deductible</td><td>50%, after deductible</td><td>50%, after deductible</td></tr>
<tr><td>Mental health/substance abuse/serious mental illness treatment</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td><td>Not covered</td></tr>
<tr><th colspan="8">Prescription drug</th></tr>
<tr><td>Prescription deductible, individual/family</td><td>None</td><td>None</td><td>None</td><td>None</td><td>None</td><td>None</td><td>None</td></tr>
<tr><td>Generic formulary copay</td><td>$10</td><td>$10</td><td>$10</td><td>$10</td><td rowspan="3">50%, no deductible</td><td>$10</td><td rowspan="3">50%, no deductible</td></tr>
<tr><td>Brand formulary copay</td><td>$30</td><td>$30</td><td>$30</td><td>$30</td><td>$30</td></tr>
<tr><td>Non-formulary copay</td><td>$50</td><td>$50</td><td>$50</td><td>$50</td><td>$50</td></tr>
<tr><td>Prescription mail order</td><td>Available</td><td>Available</td><td>Available</td><td>Available</td><td>Available</td><td>Available</td><td>Available</td></tr>
<tr><td>Maximum prescription drug benefit, individual/family</td><td>Each year you have coverage up to $2,500/$5,000</td><td>Each year you have coverage up to $2,500/$5,000</td><td>Each year you have coverage up to $2,500/$5,000</td><td colspan="2">Up to $2,500 per person, per year[†]</td><td colspan="2">Up to $2,500 per person, per year[†]</td></tr>
</table>

*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.
† 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.

2010-0089 Deductible 5/10

Benefits summary for individuals and families

Deductible 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.