Health Plans

Effective 1/1/2014

Independence Blue Solutions®

PLATINUM HEALTH PLANS

Benefits per contract year	PPO Platinum Premier	
	You pay in-network	You pay out-of-network[1]
Deductible, individual/family	None	$2,000/$4,000
Coinsurance	0%	50%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductibles)	$1,500/$3,000	$5,000/$10,000
Lifetime maximum	Unlimited	Unlimited
Preventive services		
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0	50% no ded
Nutrition counseling (6 visits per contract year)[2]	$0	50% after ded
Physician services		
Primary care office visit	$10	50% after ded
Specialist office visit	$20	50% after ded
Adult routine eye exam (once every calendar year)	$0	$40 reimb
Pediatric routine eye exam (once every calendar year)	$0	Not covered
Adult vision - eye glasses or contacts (once every calendar year)	$100 allowance	$50 reimb
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered
Spinal manipulations (20 visits per contract year)[2]	$20	50% after ded
Physical/occupational therapy (30 visits per contract year)[2]	$20	50% after ded
Outpatient surgery		
Ambulatory Surgical Center	$0	50% after ded
Hospital-based	$0	50% after ded
Outpatient laboratory & pathology		
Freestanding Lab	$0	50% after ded
Hospital-based Lab	50%	50% after ded
Hospital/other medical services		
Inpatient hospital services/days (includes maternity)	$0	50% after ded
Emergency room (not waived if admitted)	$100 no ded	$100 no ded
Routine radiology/diagnostic	$20	50% after ded
MRI/MRA, CT/CTA scan, PET scan	$175	50% after ded
Biotech/specialty injectables	$50	50% after ded
Durable medical equipment/prosthetics	30%	50% after ded
Outpatient mental health care	$20	50% after ded
Inpatient mental health care	$0	50% after ded
Outpatient serious mental illness care	$20	50% after ded
Inpatient serious mental illness care	$0	50% after ded
Substance abuse treatment		
Detox	$0	50% after ded
Rehabilitation	$0	50% after ded
Outpatient	$20	50% after ded
Prescription Drug		
Prescription deductible, individual/family	None	None
Preferred generic copay	$4	Member pays 70% of retail
Generic formulary copay	$10	Member pays 70% of retail
Brand formulary copay	$40	Member pays 70% of retail
Non-formulary copay	$70	Member pays 70% of retail

Independence

PPO Platinum		DPOS Platinum Premier		DPOS Platinum
You pay in-network	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[4]**	**You pay in-network**
None	$2,000/$4,000	None	$2,000/$4,000	None
0%	50%	0%	50%	$0
$2,000/$4,000	$5,000/$10,000	$2,000/$4,000	$5,000/$10,000	$3,000/$6,000
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0	50% no ded	$0	50% no ded	$0
$0	50% after ded	$0	50% after ded	$0
$15	50% after ded	$10	50% after ded	$15
$30	50% after ded	$20	50% after ded	$30
$0	$40 reimb	$0	$40 reimb	$0
$0	Not covered	$0	Not covered	$0
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance
Covered	Not covered	Covered	Not covered	Covered
$30	50% after ded	$20[3]	50% after ded	$30[3]
$30	50% after ded	$20[3]	50% after ded	$30[3]
$25	50% after ded	$0	50% after ded	$25
$125	50% after ded	$0	50% after ded	$125
$0	50% after ded	$0	50% after ded	$0
50%	50% after ded	$0	50% after ded	$0
$100/day up to 5 days per adm	50% after ded	$0	$50 after ded	$100/day up to 5 days per adm
$100 no ded	$100 no ded	$100 no ded	$100 no ded	$100 no ded
$30	50% after ded	$20[3]	50% after ded	$30[3]
$175	50% after ded	$40	50% after ded	$60
$75	50% after ded	$50	50% after ded	$75
30%	50% after ded	50%	50% after ded	50%
$30	50% after ded	$20	50% after ded	$30
$100/day up to 5 days per adm	50% after ded	$0	50% after ded	$100/day up to 5 days per adm
$30	50% after ded	$20	50% after ded	$30
$100/day up to 5 days per adm	50% after ded	$0	50% after ded	$100/day up to 5 days per adm
$100/day up to 5 days per adm	50% after ded	$0	50% after ded	$100/day up to 5 days per adm
$100/day up to 5 days per adm	50% after ded	$0	50% after ded	$100/day up to 5 days per adm
$30	50% after ded	$20	50% after ded	$30
None	None	None	None	None
$4	Member pays 70% of retail	$4	Member pays 70% of retail	$4
$10	Member pays 70% of retail	$10	Member pays 70% of retail	$10
$40	Member pays 70% of retail	$40	Member pays 70% of retail	$45
$70	Member pays 70% of retail	$70	Member pays 70% of retail	$75

Platinum Health Plans *continued*

Benefits per contract year	DPOS Platinum You pay out-of-network[4]	HMO Platinum Premier You pay	HMO Platinum You pay
Deductible, individual/family	$2,000/$4,000	None	None
Coinsurance	50%	0%	0%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductibles)	$5,000/$10,000	$2,000/$4,000	$3,000/$6,000
Lifetime maximum	Unlimited	Unlimited	Unlimited
Preventive services			
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	50% no ded	$0	$0
Nutrition counseling (6 visits per contract year)[2]	50% after ded	$0	$0
Physician services			
Primary care office visit	50% after ded	$10	$15
Specialist office visit	50% after ded	$20	$30
Adult routine eye exam (once every calendar year)	$40 reimb	$0	$0
Pediatric routine eye exam (once every calendar year)	Not covered	$0	$0
Adult vision - eye glasses or contacts (once every calendar year)	$50 reimb	$100 allowance	$100 allowance
Pediatric vision - eye glasses (once every calendar year)	Not covered	Covered	Covered
Spinal manipulations (20 visits per contract year)[2]	50% after ded	$20	$30
Physical/occupational therapy (30 visits per contract year)[2]	50% after ded	$20	$30
Outpatient surgery			
Ambulatory Surgical Center	50% after ded	$0	$25
Hospital-based	50% after ded	$0	$125
Outpatient laboratory & pathology			
Freestanding Lab	50% after ded	$0	$0
Hospital-based Lab	50% after ded	$0	$0
Hospital/other medical services			
Inpatient hospital services/days (includes maternity)	50% after ded	$0	$100/day up to 5 days per adm
Emergency room (not waived if admitted)	$100 no ded	$100	$100
Routine radiology/diagnostic	50% after ded	$20	$30
MRI/MRA, CT/CTA scan, PET scan	50% after ded	$40	$60
Biotech/specialty injectables	50% after ded	$50	$75
Durable medical equipment/prosthetics	50% after ded	50%	50%
Outpatient mental health care	50% after ded	$20	$30
Inpatient mental health care	50% after ded	$0	$100/day up to 5 days per adm
Outpatient serious mental illness care	50% after ded	$20	$30
Inpatient serious mental illness care	50% after ded	$0	$100/day up to 5 days per adm
Substance abuse treatment			
Detox	50% after ded	$0	$100/day up to 5 days per adm
Rehabilitation	50% after ded	$0	$100/day up to 5 days per adm
Outpatient	50% after ded	$20	$30
Prescription Drug			
Prescription deductible, individual/family	None	None	None
Preferred generic copay	Member pays 70% of retail	$4	$4
Generic formulary copay	Member pays 70% of retail	$10	$10
Brand formulary copay	Member pays 70% of retail	$40	$45
Non-formulary copay	Member pays 70% of retail	$70	$75

[1]Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), 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, 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, the payment is based on 50% of the actual charge of the provider. 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.

PPO Platinum HRA 50 Employer Contribution - $750 (Individual)/$1,500 (Family)		PPO Platinum HSA 50 Employer Contribution - $750 (Individual)/$1,500 (Family)	
You pay in-network	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[1]**
$1,500/$3,000	$10,000/$20,000	$1,500/$3,000	$10,000/$20,000
0%	50%	0%	50%
$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000
Unlimited	Unlimited	Unlimited	Unlimited
$0 no ded	50% no ded	$0 no ded	50% no ded
$0 no ded	50% after ded	$0 no ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	$40 reimb	$0 after ded	$40 reimb
$0 after ded	Not covered	$0 after ded	Not covered
$100 allowance	$50 reimb	$100 allowance	$50 reimb
Covered	Not covered	Covered	Not covered
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	$0 after in-network ded	$0 after ded	$0 after in-network ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	50% after ded	$0 after ded	50% after ded
Integrated	Integrated	Integrated	Integrated
$4	50% after ded	$4	50% after ded
$10 after ded	50% after ded	$10 after ded	50% after ded
$40 after ded	50% after ded	$40 after ded	50% after ded
$60 after ded	50% after ded	$60 after ded	50% after ded

[2]For PPO plans, visit limits are combined in- and out-of-network.

[3]Referral required from primary care physician.

[4]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.

GOLD HEALTH PLANS

Benefits per contract year	PPO Gold Premier		PPO Gold	
	You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]
Deductible, individual/family	None	$6,000/$12,000	$1,000/$2,000	$7,500/$15,000
Coinsurance	0%	50%	10%	50%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductible)	$4,500/$9,000	$18,000/$36,000	$4,500/$9,000	$25,000/$50,000
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive services				
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0	50% no ded	$0 no ded	50% no ded
Nutrition counseling (6 visits per contract year)[2]	$0	50% after ded	$0 no ded	50% after ded
Physician services				
Primary care office visit	$40	50% after ded	$20 no ded	50% after ded
Specialist office visit	$75	50% after ded	$40 no ded	50% after ded
Adult routine eye exam (once every calendar year)	$0	$40 reimb	$0 no ded	$40 reimb
Pediatric routine eye exam (once every calendar year)	$0	Not covered	$0 no ded	Not covered
Adult vision - eye glasses or contacts (once every calendar year)	$100 Allowance	$50 reimb	$100 allowance	$50 reimb
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered	Covered	Not covered
Spinal manipulations (20 visits per contract year)[2]	$75	50% after ded	$40 no ded	50% after ded
Physical/occupational therapy (30 visits per contract year)[2]	$75	50% after ded	$40 no ded	50% after ded
Outpatient surgery				
Ambulatory Surgical Center	$450	50% after ded	10% after ded	50% after ded
Hospital-based	$850	50% after ded	10% after ded	50% after ded
Outpatient laboratory & pathology				
Freestanding Lab	$0	50% after ded	10% after ded	50% after ded
Hospital-based Lab	50%	50% after ded	10% after ded	50% after ded
Hospital/other medical services				
Inpatient hospital services/days (includes maternity)	$750/day up to 5 days per adm	50% after ded	10% after ded	50% after ded
Emergency room (not waived if admitted)	$150 no ded	$150 no ded	10% after ded	10% after in-network ded
Routine radiology/diagnostic	$75	50% after ded	10% after ded	50% after ded
MRI/MRA, CT/CTA scan, PET scan	$175	50% after ded	10% after ded	50% after ded
Biotech/specialty injectables	$125	50% after ded	$100 no ded	50% after ded
Durable medical equipment/prosthetics	50%	50% after ded	50% after ded	50% after ded
Outpatient mental health care	$75	50% after ded	$40 no ded	50% after ded
Inpatient mental health care	$750/day up to 5 days per adm	50% after ded	10% after ded	50% after ded
Outpatient serious mental illness care	$75	50% after ded	$40 no ded	50% after ded
Inpatient serious mental illness care	$750/day up to 5 days per adm	50% after ded	10% after ded	50% after ded
Substance abuse treatment				
Detox	$750/day up to 5 days per adm	50% after ded	10% after ded	50% after ded
Rehabilitation	$750/day up to 5 days per adm	50% after ded	10% after ded	50% after ded
Outpatient	$75	50% after ded	$40 no ded	50% after ded
Prescription Drug				
Prescription deductible, individual/family	None	None	$250 (brand)	None
Preferred generic copay	$4	Member pays 70% of retail	$4	Member pays 70% of retail
Generic formulary copay	$10	Member pays 70% of retail	$10 no ded	Member pays 70% of retail
Brand formulary copay	$45	Member pays 70% of retail	$45 after ded	Member pays 70% of retail
Non-formulary copay	$75	Member pays 70% of retail	$75 after ded	Member pays 70% of retail

Independence

DPOS Gold Premier		DPOS Gold		HMO Gold Premier	HMO Gold
You pay in-network	You pay out-of-network[4]	You pay in-network	You pay out-of-network[4]	You pay	You pay
None	$5,000/$10,000	$1,000/$2,000	$7,500/$15,000	None	$1,000/$2,000
0%	50%	10%	50%	0%	10%
$6,350/$12,700	$15,000/$30,000	$6,350/$12,700	$25,000/$50,000	$6,350/$12,700	$6,350/$12,700
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0	50% no ded	$0 no ded	50% no ded	$0	$0 no ded
$0	50% after ded	$0 no ded	50% after ded	$0	$0 no ded
$30	50% after ded	$20 no ded	50% after ded	$30	$20 no ded
$60	50% after ded	$40 no ded	50% after ded	$60	$40 no ded
$0	$40 reimb	$0 no ded	$40 reimb	$0	$0 no ded
$0	Not covered	$0 no ded	Not covered	$0	$0 no ded
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$100 allowance
Covered	Not covered	Covered	Not covered	Covered	Covered
$60[3]	50% after ded	$40 no ded[3]	50% after ded	$60	$40 no ded
$60[3]	50% after ded	$40 no ded[3]	50% after ded	$60	$40 no ded
$250	50% after ded	10% after ded	50% after ded	$250	10% after ded
$450	50% after ded	10% after ded	50% after ded	$450	10% after ded
$0	50% after ded	$0 no ded	50% after ded	$0	$0 no ded
$0	50% after ded	$0 no ded	50% after ded	$0	$0 no ded
$500/day up to 5 days per adm	50% after ded	10% after ded	50% after ded	$500/day up to 5 days per adm	10% after ded
$250 no ded	$250 no ded	10% after ded	10% after in-network ded	$250	10% after ded
$60[3]	50% after ded	$40 no ded[3]	50% after ded	$60	$40 no ded
$250	50% after ded	$80 no ded	50% after ded	$250	$80 no ded
$125	50% after ded	$100 no ded	50% after ded	$125	$100 no ded
50%	50% after ded	50% after ded	50% after ded	50%	50% after ded
$60	50% after ded	$40 no ded	50% after ded	$60	$40 no ded
$500/day up to 5 days per adm	50% after ded	10% after ded	50% after ded	$500/day up to 5 days per adm	10% after ded
$60	50% after ded	$40 no ded	50% after ded	$60	$40 no ded
$500/day up to 5 days per adm	50% after ded	10% after ded	50% after ded	$500/day up to 5 days per adm	10% after ded
$500/day up to 5 days per adm	50% after ded	10% after ded	50% after ded	$500/day up to 5 days per adm	10% after ded
$500/day up to 5 days per adm	50% after ded	10% after ded	50% after ded	$500/day up to 5 days per adm	10% after ded
$60	50% after ded	$40 no ded	50% after ded	$60	$40 no ded
None	None	None	None	None	None
$4	Member pays 70% of retail	$4	Member pays 70% of retail	$4	$4
$10	Member pays 70% of retail	$10	Member pays 70% of retail	$10	$10
$50	Member pays 70% of retail	$50	Member pays 70% of retail	$50	$50
$75	Member pays 70% of retail	$75	Member pays 70% of retail	$75	$75

Gold Health Plans *continued*

Benefits per contract year	PPO Gold HRA 25 Employer Contribution level - $500 (Individual)/$1,000 (Family)		PPO Gold HRA	
	You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]
Deductible, individual/family	$2,000/$4,000	$10,000/$20,000	$1,500/$3,000	$10,000/$20,000
Coinsurance	0%	50%	0%	50%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductible)	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000
Lifetime maximum	Unlimited	Unlimited	Unlimited	Unlimited
Preventive services				
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0 no ded	50% no ded	$0 no ded	50% no ded
Nutrition counseling (6 visits per contract year)[2]	$0 no ded	50% after ded	$0 no ded	50% after ded
Physician services				
Primary care office visit	$0 after ded	50% after ded	$0 after ded	50% after ded
Specialist office visit	$0 after ded	50% after ded	$0 after ded	50% after ded
Adult routine eye exam (once every calendar year)	$0 after ded	$40 reimb	$0 after ded	$40 reimb
Pediatric routine eye exam (once every calendar year)	$0 after ded	Not covered	$0 after ded	Not covered
Adult vision - eye glasses or contacts (once every calendar year)	$100 allowance	$50 reimb	$100 allowance	$50 reimb
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered	Covered	Not covered
Spinal manipulations (20 visits per contract year)[2]	$0 after ded	50% after ded	$0 after ded	50% after ded
Physical/occupational therapy (30 visits per contract year)[2]	$0 after ded	50% after ded	$0 after ded	50% after ded
Outpatient surgery				
Ambulatory Surgical Center	$0 after ded	50% after ded	$0 after ded	50% after ded
Hospital-based	$0 after ded	50% after ded	$0 after ded	50% after ded
Outpatient laboratory & pathology				
Freestanding Lab	$0 after ded	50% after ded	$0 after ded	50% after ded
Hospital-based Lab	$0 after ded	50% after ded	$0 after ded	50% after ded
Hospital/other medical services				
Inpatient hospital services/days (includes maternity)	$0 after ded	50% after ded	$0 after ded	50% after ded
Emergency room (not waived if admitted)	$0 after ded	$0 after in-network ded	$0 after ded	$0 after in-network ded
Routine radiology/diagnostic	$0 after ded	50% after ded	$0 after ded	50% after ded
MRI/MRA, CT/CTA scan, PET scan	$0 after ded	50% after ded	$0 after ded	50% after ded
Biotech/specialty injectables	$0 after ded	50% after ded	$0 after ded	50% after ded
Durable medical equipment/prosthetics	$0 after ded	50% after ded	$0 after ded	50% after ded
Outpatient mental health care	$0 after ded	50% after ded	$0 after ded	50% after ded
Inpatient mental health care	$0 after ded	50% after ded	$0 after ded	50% after ded
Outpatient serious mental illness care	$0 after ded	50% after ded	$0 after ded	50% after ded
Inpatient serious mental illness care	$0 after ded	50% after ded	$0 after ded	50% after ded
Substance abuse treatment				
Detox	$0 after ded	50% after ded	$0 after ded	50% after ded
Rehabilitation	$0 after ded	50% after ded	$0 after ded	50% after ded
Outpatient	$0 after ded	50% after ded	$0 after ded	50% after ded
Prescription Drug				
Prescription deductible, individual/family	Integrated	Integrated	Integrated	Integrated
Preferred generic copay	$4	50% after ded	$4	50% after ded
Generic formulary copay	$10 after ded	50% after ded	$10 after ded	50% after ded
Brand formulary copay	$40 after ded	50% after ded	$40 after ded	50% after ded
Non-formulary copay	$60 after ded	50% after ded	$60 after ded	50% after ded

[1]Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), 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, 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, the payment is based on 50% of the charge of the provider. 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.

PPO Gold HRA 50 Employer Contribution - $1,000 (Individual)/$2,000 (Family)		PPO Gold HSA 25 Employer Contribution - $500 (Individual)/$1,000(Family)		PPO Gold HSA		PPO Gold HSA 50 Employer Contribution - $1,000 (Individual)/$2,000 (Family)	
You pay in-network	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[1]**	**You pay in-network**	**You pay out-of-network[1]**
$2,000/$4,000	$10,000/$20,000	$2,000/$4,000	$10,000/$20,000	$1,500/$3,000	$10,000/$20,000	$2,000/$4,000	$10,000/$20,000
30%	50%	0%	50%	0%	50%	30%	50%
$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	50% no ded
$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
$0 after ded	$40 reimb	$0 after ded	$40 reimb	$0 after ded	$40 reimb	$0 after ded	$40 reimb
$0 after ded	Not covered	$0 after ded	Not covered	$0 after ded	Not covered	$0 after ded	Not covered
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$50 reimb
Covered	Not covered	Covered	Not covered	Covered	Not covered	Covered	Not covered
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	30% after in-network ded	$0 after ded	$0 after in-network ded	$0 after ded	$0 after in-network ded	30% after ded	30% after in-network ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
30% after ded	50% after ded	$0 after ded	50% after ded	$0 after ded	50% after ded	30% after ded	50% after ded
Integrated	Integrated	Integrated	Integrated	Integrated	Integrated	Integrated	Integrated
$4	50% after ded	$4	50% after ded	$4	50% after ded	$4	50% after ded
$10 after ded	50% after ded	$10 after ded	50% after ded	$10 after ded	50% after ded	$10 after ded	50% after ded
$40 after ded	50% after ded	$40 after ded	50% after ded	$40 after ded	50% after ded	$40 after ded	50% after ded
$60 after ded	50% after ded	$60 after ded	50% after ded	$60 after ded	50% after ded	$60 after ded	50% after ded

GOLD

[2]For PPO plans, visit limits are combined in- and out-of-network.

[3]Referral required from primary care physician.

[4]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.

SILVER HEALTH PLANS

Benefits per contract year	PPO Silver You pay in-network	PPO Silver You pay out-of-network[1]
Deductible, individual/family	$2,000/$4,000	$7,500/$15,000
Coinsurance	20%	50%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductible)	$5,500/$11,000	$25,000/$50,000
Lifetime maximum	Unlimited	Unlimited
Preventive services		
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0 no ded	50% no ded
Nutrition counseling (6 visits per contract year)[2]	$0 no ded	50% after ded
Physician services		
Primary care office visit	$30 no ded	50% after ded
Specialist office visit	$50 no ded	50% after ded
Adult routine eye exam (once every calendar year)	$0 no ded	$40 reimb
Pediatric routine eye exam (once every calendar year)	$0 no ded	Not covered
Adult vision - eye glasses or contacts (once every calendar year)	$100 allowance	$50 reimb
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered
Spinal manipulations (20 visits per contract year)[2]	$50 no ded	50% after ded
Physical/occupational therapy (30 visits per contract year)[2]	$50 no ded	50% after ded
Outpatient surgery		
Ambulatory Surgical Center	20% after ded	50% after ded
Hospital-based	20% after ded	50% after ded
Outpatient laboratory & pathology		
Freestanding Lab	20% after ded	50% after ded
Hospital-based Lab	20% after ded	50% after ded
Hospital/other medical services		
Inpatient hospital services/days (includes maternity)	20% after ded	50% after ded
Emergency room (not waived if admitted)	20% after ded	20% after in-network ded
Routine radiology/diagnostic	20% after ded	50% after ded
MRI/MRA, CT/CTA scan, PET scan	20% after ded	50% after ded
Biotech/specialty injectables	$100 no ded	50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Outpatient mental health care	$50 no ded	50% after ded
Inpatient mental health care	20% after ded	50% after ded
Outpatient serious mental illness care	$50 no ded	50% after ded
Inpatient serious mental illness care	20% after ded	50% after ded
Substance abuse treatment		
Detox	20% after ded	50% after ded
Rehabilitation	20% after ded	50% after ded
Outpatient	$50 no ded	50% after ded
Prescription Drug		
Prescription deductible, individual/family	None	None
Preferred generic copay	$4	Member pays 70% of retail
Generic formulary copay	$10 no ded[5]	Member pays 70% of retail
Brand formulary copay	50% up to $125 max per prescription	Member pays 70% of retail
Non-formulary copay	50% up to $125 max per prescription	Member pays 70% of retail

Independence

DPOS Silver Premier		DPOS Silver		HMO Silver Premier	HMO Silver
You pay in-network	You pay out-of-network[4]	You pay in-network	You pay out-of-network[4]	You pay	You pay
$2,000/$4,000	$7,500/$15,000	$2,000/$4,000	$7,500/$15,000	$2,000/$4,000	$2,000/$4,000
30%	50%	40%	50%	30%	40%
$6,350/$12,700	$25,000/$50,000	$6,350/$12,700	$25,000/$50,000	$6,350/$12,700	$6,350/$12,700
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	$0 no ded
$0 no ded	50%, after ded	$0 no ded	50% after ded	$0 no ded	$0 no ded
$25 no ded	50% after ded	$30 no ded	50% after ded	$25 no ded	$30 no ded
$50 no ded	50% after ded	$60 no ded	50% after ded	$50 no ded	$60 no ded
$0 no ded	$40 reimb	$0 no ded	$40 reimb	$0 no ded	$0 no ded
$0 no ded	Not covered	$0 no ded	Not covered	$0 no ded	$0 no ded
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$100 allowance
Covered	Not covered	Covered	Not covered	Covered	Covered
$50 no ded[3]	50% after ded	$60 no ded[3]	50% after ded	$50 no ded	$60 no ded
$50 no ded[3]	50% after ded	$60 no ded[3]	50% after ded	$50 no ded	$60 no ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	$0 no ded
$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	$0 no ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
30% after ded	30% after in-network ded	40% after ded	40% after in-network ded	30% after ded	40% after ded
$50 no ded[3]	50% after ded	$60 no ded[3]	50% after ded	$50 no ded	$60 no ded
$100 no ded	50% after ded	$120 no ded	50% after ded	$100 no ded	$120 no ded
$100 no ded	50% after ded	$100 no ded	50% after ded	$100 no ded	$100 no ded
50% after ded	50% after ded	50% after ded	50% after ded	50% after ded	50% after ded
$50 no ded	50% after ded	$60 no ded	50% after ded	$50 no ded	$60 no ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
$50 no ded	50% after ded	$60 no ded	50% after ded	$50 no ded	$60 no ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
30% after ded	50% after ded	40% after ded	50% after ded	30% after ded	40% after ded
$50 no ded	50% after ded	$60 no ded	50% after ded	$50 no ded	$60 no ded
$250	None	None	None	$250	None
$4	Member pays 70% of retail	$4	Member pays 70% of retail	$4	$4
$20 after ded[5]	Member pays 70% of retail	$10 no ded[5]	Member pays 70% of retail	$20 after ded[5]	$10 no ded[5]
$40 after ded	Member pays 70% of retail	50% up to $125 max per prescription	Member pays 70% of retail	$40 after ded	50% up to $125 max per prescription
$60 after ded	Member pays 70% of retail	50% up to $125 max per prescription	Member pays 70% of retail	$60 after ded	50% up to $125 max per prescription

Silver Health Plans *continued*

Benefits per contract year	PPO Silver HRA 25 Employer Contribution - $500 (Individual)/$1,000 (Family)	
	You pay in-network	You pay out-of-network[1]
Deductible, individual/family	$2,000/$4,000	$10,000/$20,000
Coinsurance	50%	50%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductible)	$6,350/$12,700	$20,000/$40,000
Lifetime maximum	Unlimited	Unlimited
Preventive services		
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0 no ded	50% no ded
Nutrition counseling (6 visits per contract year)[2]	$0 no ded	50% after ded
Physician services		
Primary care office visit	50% after ded	50% after ded
Specialist office visit	50% after ded	50% after ded
Adult routine eye exam (once every calendar year)	$0 after ded	$40 reimb
Pediatric routine eye exam (once every calendar year)	$0 after ded	Not covered
Adult vision - eye glasses or contacts (once every calendar year)	$100 allowance	$50 reimb
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered
Spinal manipulations (20 visits per contract year)[2]	50% after ded	50% after ded
Physical/occupational therapy (30 visits per contract year)[2]	50% after ded	50% after ded
Outpatient surgery		
Ambulatory Surgical Center	50% after ded	50% after ded
Hospital-based	50% after ded	50% after ded
Outpatient laboratory & pathology		
Freestanding Lab	50% after ded	50% after ded
Hospital-based Lab	50% after ded	50% after ded
Hospital/other medical services		
Inpatient hospital services/days (includes maternity)	50% after ded	50% after ded
Emergency room (not waived if admitted)	50% after ded	50% after in-network ded
Routine radiology/diagnostic	50% after ded	50% after ded
MRI/MRA, CT/CTA scan, PET scan	50% after ded	50% after ded
Biotech/specialty injectables	50% after ded	50% after ded
Durable medical equipment/prosthetics	50% after ded	50% after ded
Outpatient mental health care	50 % after ded	50% after ded
Inpatient mental health care	50% after ded	50% after ded
Outpatient serious mental illness care	50% after ded	50% after ded
Inpatient serious mental illness care	50% after ded	50% after ded
Substance abuse treatment		
Detox	50% after ded	50% after ded
Rehabilitation	50% after ded	50% after ded
Outpatient	50% after ded	50% after ded
Prescription Drug		
Prescription deductible, individual/family	Integrated	Integrated
Preferred generic copay	$4	50% after ded
Generic formulary copay	$10 after ded	50% after ded
Brand formulary copay	$40 after ded	50% after ded
Non-formulary copay	$60 after ded	50% after ded

[1]Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), 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, 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, the payment is based on 50% of the actual charge of the provider. 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.

PPO Silver HRA		PPO Silver HSA 25 Employer Contribution - $500 (Individual)/$1,000 (Family)		PPO Silver HSA	
You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]
$2,000/$4,000	$10,000/$20,000	$2,000/$4,000	$10,000/$20,000	$2,000/$4,000	$10,000/$20,000
10%	50%	50%	50%	10%	50%
$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	50% no ded
$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
$0 after ded	$40 reimb	$0 after ded	$40 reimb	$0 after ded	$40 reimb
$0 after ded	Not covered	$0 after ded	Not covered	$0 after ded	Not covered
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$50 reimb
Covered	Not covered	Covered	Not covered	Covered	Not covered
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	10% after in-network ded	50% after ded	50% after in-network ded	10% after ded	10% after in-network ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
10% after ded	50% after ded	50% after ded	50% after ded	10% after ded	50% after ded
Integrated	Integrated	Integrated	Integrated	Integrated	Integrated
$4	50% after ded	$4	50% after ded	$4	50% after ded
$10 after ded	50% after ded	$10 after ded	50% after ded	$10 after ded	50% after ded
$40 after ded	50% after ded	$40 after ded	50% after ded	$40 after ded	50% after ded
$60 after ded	50% after ded	$60 after ded	50% after ded	$60 after ded	50% after ded

[2]For PPO plans, visit limits are combined in- and out-of-network.
[3]Referral required from primary care physician.
[4]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.
[5]Mandatory generics.

B BRONZE HEALTH PLANS

Benefits per contract year	DPOS Bronze		HMO Bronze
	You pay in-network	You pay out-of-network[4]	You pay
Deductible, individual/family	$6,000/$12,000	$10,000/$20,000	$6,000/$12,000
Coinsurance	0%	50%	0%
Out-of-pocket maximum, individual/family (includes copays, coinsurance and deductible)	$6,350/$12,700	$40,000/$80,000	$6,350/$12,700
Lifetime maximum	Unlimited	Unlimited	Unlimited
Preventive services			
Preventive care for adults and children (includes mammogram, routine gynecological, and pediatric immunization)	$0 no ded	50% no ded	$0 no ded
Nutrition counseling (6 visits per contract year)[2]	$0 no ded	50% after ded	$0 no ded
Physician services			
Primary care office visit	$40 no ded	50% after ded	$40 no ded
Specialist office visit	$80 no ded	50% after ded	$80 no ded
Adult routine eye exam (once every calendar year)	$0 no ded	$40 reimb	$0 no ded
Pediatric routine eye exam (once every calendar year)	$0 no ded	Not covered	$0 no ded
Adult vision - eye glasses or contacts (once every calendar year)	$100 allowance	$50 reimb	$100 allowance
Pediatric vision - eye glasses (once every calendar year)	Covered	Not covered	Covered
Spinal manipulations (20 visits per contract year)[2]	$80 no ded[3]	50% after ded	$80 no ded
Physical/occupational therapy (30 visits per contract year)[2]	$80 no ded[3]	50% after ded	$80 no ded
Outpatient surgery			
Ambulatory Surgical Center	$0 after ded	50% after ded	$0 after ded
Hospital-based	$0 after ded	50% after ded	$0 after ded
Outpatient laboratory & pathology			
Freestanding Lab	$0 no ded	50% after ded	$0 no ded
Hospital-based Lab	$0 no ded	50% after ded	$0 no ded
Hospital/other medical services			
Inpatient hospital services/days (includes maternity)	$0 after ded	50% after ded	$0 after ded
Emergency room (not waived if admitted)	$0 after ded	$0 after in-network ded	$0 after ded
Routine radiology/diagnostic	$60 no ded[3]	50% after ded	$60 no ded
MRI/MRA, CT/CTA scan, PET scan	$250 no ded	50% after ded	$250 no ded
Biotech/specialty injectables	$100 no ded	50% after ded	$100 no ded
Durable medical equipment/prosthetics	50% after ded	50% after ded	50% after ded
Outpatient mental health care	$80 no ded	50% after ded	$80 no ded
Inpatient mental health care	$0 after ded	50% after ded	$0 after ded
Outpatient serious mental illness care	$80 no ded	50% after ded	$80 no ded
Inpatient serious mental illness care	$0 after ded	50% after ded	$0 after ded
Substance abuse treatment			
Detox	$0 after ded	50% after ded	$0 after ded
Rehabilitation	$0 after ded	50% after ded	$0 after ded
Outpatient	$80 no ded	50% after ded	$80 no ded
Prescription Drug (FutureScripts Preferred Pharmacy Network)			
Prescription deductible, individual/family	Integrated[5]	Integrated	Integrated[5]
Preferred generic copay	$4	Members pays 70% of retail after ded	$4
Generic formulary copay	$10 no ded[6]	Members pays 70% of retail after ded	$10 no ded[6]
Brand formulary copay	$0 after ded	Members pays 70% of retail after ded	$0 after ded
Non-formulary copay	$0 after ded	Members pays 70% of retail after ded	$0 after ded

[1]Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), 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, payment is based on the lesser of the Independence Blue Cross (IBC) applicable proprietary fee schedule or the actual

Independence

PPO Bronze HRA Premier		PPO Bronze HRA		PPO Bronze HSA Premier		PPO Bronze HSA	
You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]	You pay in-network	You pay out-of-network[1]
$3,000/$6,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000	$3,000/$6,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
50%	50%	0%	50%	50%	50%	0%	50%
$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000	$6,350/$12,700	$20,000/$40,000
Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	50% no ded	$0 no ded	50% no ded
$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	50% after ded	$0 no ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
$0 after ded	$40 reimb	$0 after ded	$40 reimb	$0 after ded	$40 reimb	$0 after ded	$40 reimb
$0 after ded	Not covered	$0 after ded	Not covered	$0 after ded	Not covered	$0 after ded	Not covered
$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$50 reimb	$100 allowance	$50 reimb
Covered	Not covered	Covered	Not covered	Covered	Not covered	Covered	Not covered
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after in-network ded	$0 after ded	$0 after in-network ded	50% after ded	50% after in-network ded	$0 after ded	$0 after in-network ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
50% after ded	50% after ded	$0 after ded	50% after ded	50% after ded	50% after ded	$0 after ded	50% after ded
Integrated[5]	Integrated	Integrated[5]	Integrated	Integrated[5]	Integrated	Integrated[5]	Integrated
$4	50% after ded	$4	50% after ded	$4	50% after ded	$4	50% after ded
$10 after ded[6]	50% after ded	$10 after ded[6]	50% after ded	$10 after ded[6]	50% after ded	$10 after ded[6]	50% after ded
$40 after ded	50% after ded	$40 after ded	50% after ded	$40 after ded	50% after ded	$40 after ded	50% after ded
$60 after ded	50% after ded	$60 after ded	50% after ded	$60 after ded	50% after ded	$60 after ded	50% after ded

charge of the provider. For covered services not recognized or reimbursed by Medicare or IBC's fee schedule, the payment is based on 50% of the actual charge of the provider. 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. [2]For PPO plans, visit limits are combined in- and out-of-network. [3]Referral required from primary care physician. [4]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. [5]FutureScripts Preferred Pharmacy network which is a subset of the national retail pharmacy network and includes over 50,000 pharmacies, including most national retail chains and local pharmacies, applies to this plan. [6]Mandatory generics.

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;
- 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);
- bariatric/obesity surgery;
- outpatient private duty nursing.

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).

Independence Blue Solutions®

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