# Personal Choice

## PPO Plus 2B

Personal Choice® our popular Preferred Provider Organization (PPO), gives you freedom of choice by allowing you to choose your own doctors and hospitals. You can maximize your coverage by accessing your care through Personal Choice's network of hospitals, doctors, and specialists, or by accessing care through preferred providers that participate in the BlueCard® PPO program. Of course, with Personal Choice, you have the freedom to select providers who do not participate in the Personal Choice network or BlueCard PPO program. However, if you receive services from out-of-network providers, you will have higher out-of-pocket costs and may have to submit your claim for reimbursement.

With Personal Choice...

- You do not need to enroll with a primary care physician
- You never need a referral

| Benefit | In-network | Out-of-network[1] |
|---|---|---|
| **BENEFIT PERIOD** | Calendar Year* | Calendar Year* |
| **DEDUCTIBLE** | | |
| Individual | $0 | $500 |
| Family | $0 | $1,500 |
| **OUT-OF-POCKET MAXIMUM**[6] | | |
| Individual | $6,600 | $10,000 |
| Family | $13,200 | $30,000 |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **DOCTOR'S OFFICE VISITS** | | |
| Primary care services | $15 copayment | 70%, after deductible |
| Specialist services | $30 copayment | 70%, after deductible |
| **PREVENTIVE CARE FOR ADULTS AND CHILDREN** | 100% | 70%, no deductible |
| **PEDIATRIC IMMUNIZATIONS** | 100% (office visit copayment does not apply) | 70%, no deductible |
| **ROUTINE GYNECOLOGICAL EXAM/PAP** *1 per year for women of any age*[3] | 100% | 70%, no deductible |
| **MAMMOGRAM** | 100% | 70%, no deductible |
| **NUTRITION COUNSELING FOR WEIGHT MANAGEMENT** *6 visits per year*[3] | 100% | 70%, after deductible |
| **OUTPATIENT LABORATORY/PATHOLOGY** | 100% | 70%, after deductible |

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.

3 Combined in/out-of-network

* A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each calendar year on January 1.

6 The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible. The out-of-network out-of-pocket maximum includes coinsurance only.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Independence

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

**www.ibx.com**

06/14 - PA - 51+ PPO Plus 2B - OOPM 2015
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| Benefit | In-network | Out-of-network[1] |
|---|---|---|
| **MATERNITY** | | |
| First OB visit | $15 copayment | 70%, after deductible |
| Hospital | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |
| **INPATIENT HOSPITAL SERVICES** | | |
| Facility | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |
| Physician/Surgeon | 100% | 70%, after deductible |
| **INPATIENT HOSPITAL DAYS** | Unlimited | 70[5] |
| **OUTPATIENT SURGERY** | | |
| Facility | $50 copayment | 70%, after deductible |
| Physician/Surgeon | 100% | 70%, after deductible |
| **EMERGENCY ROOM** | $125 copayment (copayment not waived if admitted) | $125 copayment (copayment not waived if admitted) |
| **URGENT CARE CENTER** | $87 copayment | 70%, after deductible |
| **AMBULANCE** | | |
| Emergency | 100% | 100%, no deductible |
| Non-emergency | 100% | 70%, after deductible |
| **OUTPATIENT X-RAY/RADIOLOGY** *(Copayment not applicable when service performed in ER or office setting)* | | |
| Routine Radiology/Diagnostic | $30 copayment | 70%, after deductible |
| MRI/MRA, CT/CTA Scan, PET Scan | $60 copayment | 70%, after deductible |
| **THERAPY SERVICES** | | |
| Physical and occupational 30 total visits per year for PT/OT combined[3] | $30 copayment | 70%, after deductible |
| Cardiac rehabilitation 36 visits per year[3] | $30 copayment | 70%, after deductible |
| Pulmonary rehabilitation 36 visits per year[3] | $30 copayment | 70%, after deductible |
| Speech 20 visits per year[3] | $30 copayment | 70%, after deductible |
| Orthoptic/Pleoptic 8 session lifetime maximum[3] | $30 copayment | 70%, after deductible |
| **SPINAL MANIPULATIONS** *20 visits per year[3]* | $30 copayment | 70%, after deductible |
| **ALLERGY INJECTIONS** *(Office visit copayment waived if no office visit is charged)* | 100% | 70%, after deductible |
| **INJECTABLE MEDICATIONS** | | |
| Standard Injectables | 100%[2] | 70%, after deductible |
| Biotech/Specialty Injectables | $75 copayment | 70%, after deductible |
| **CHEMO/RADIATION/DIALYSIS** | 100% | 70%, after deductible |
| **OUTPATIENT PRIVATE DUTY NURSING** *360 hours per year[3]* | 90% | 70%, after deductible |
| **SKILLED NURSING FACILITY** *120 days per year[3]* | $50/day; maximum of 5 copayments/admission[4] | 70%, after deductible |
| **HOSPICE AND HOME HEALTH CARE** | 100% | 70%, after deductible |
| **DURABLE MEDICAL EQUIPMENT** | 70% | 50%, after deductible |
| **PROSTHETICS** | 70% | 50%, after deductible |

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2 Office visit subject to copayment

3 Combined in/out-of-network

4 Copayment waived if readmitted within 10 days of discharge

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

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

| Benefit | In-network | Out-of-network[1] |
|---|---|---|
| **MENTAL HEALTH CARE** | | |
| Outpatient | $30 copayment | 70%, after deductible |
| Inpatient | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |
| **SERIOUS MENTAL ILLNESS CARE** | | |
| Outpatient | $30 copayment | 70%, after deductible |
| Inpatient | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |
| **SUBSTANCE ABUSE TREATMENT** | | |
| Outpatient/Partial facility visits | $30 copayment | 70%, after deductible |
| Rehabilitation | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |
| Detoxification | $100/day; maximum of 5 copayments/admission[4] | 70%, after deductible[5] |

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The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

## What is not covered?

- services not medically necessary
- services or supplies that are experimental or investigative except routine costs associated with 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 non-member recipients
- alternative therapies/complementary medicine
- dental care, including dental implants, 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 resulting from 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 prostheses including wigs intended to replace hair
- routine physical exams for nonpreventive purposes such as insurance or employment applications, college, or premarital examinations
- immunizations for travel or employment
- services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- cosmetic services/supplies
- self-injectable drugs
- vision care (except as specified in a group contract)

This summary represents only a partial listing of the benefits and exclusions of the Personal Choice Program described in this summary. If your employer purchases another program, the benefits and exclusions may differ. Also, benefits and exclusions may be further defined by medical policy. As a result, this managed care plan may not cover all of your health care expenses. Read your contract/member handbook carefully for a complete listing of the terms, limitations, and exclusions of the program. If you need more information, please call 1-800-ASK-BLUE (1-800-275-2583).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.

# Select Drug Program

## $10/$20/$35

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program® is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

| Benefit | Coverage |
|---|---|
| Retail Pharmacy - Member Cost Sharing (Participating Pharmacy) | |
| Generic Formulary | $10 Copayment |
| Brand Formulary | $20 Copayment |
| Non-Formulary Brand | $35 Copayment |
| Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy)<br>*Available for maintenance drugs* | |
| Generic Formulary | $10 Copayment (1-30 days supply); $20 Copayment (31-90 days supply) |
| Brand Formulary | $20 Copayment (1-30 days supply); $40 Copayment (31-90 days supply) |
| Non-Formulary Brand | $35 Copayment (1-30 days supply); $70 Copayment (31-90 days supply) |
| Total Out-of-Pocket Maximum | Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan. |
| Out-of-Network Reimbursement | 30% of drugs retail cost for the total amount dispensed. Member must submit for reimbursement. |
| Network | FutureScripts® network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature. |
| Dispensing Limits | |
| Retail | Up to 30 days supply |
| Mail order for maintenance drugs | Up to 90 days supply |
| Formulary | IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**. |
| Specialty Pharmacy Program<br>*Mandatory for Self-Administered Specialty Drugs* | All covered self-administered specialty medications except insulin will be provided through the convenient Specialty Pharmacy Program for the appropriate cost sharing indicated above. Benefits are available for up to a thirty (30) days supply. If your doctor wants you to start the drug immediately, an initial 30-day supply may be obtained at a retail pharmacy. However, all subsequent fills must be purchased through the Specialty Pharmacy Program. |

Independence



07/14 - PA - PC Select RX Rider $10/$20/$35 w/ OralsOOPM 2015
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| Benefit | Coverage |
|---|---|
| Covered Prescription Drugs[1] | Compound medications of which at least one ingredient is a prescription drug |
| | Contraceptives |
| | Prescribed smoking cessation drugs |
| | Retin-A through age 35 |
| | Self-injectable drugs |
| | Insulin |
| | Insulin needles and syringes |
| | Lancets (no copayment required at participating pharmacies) |
| | Glucometers (no copayment required at participating pharmacies) |
| | Diabetic supplies (i.e test strips) |

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

## What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Experimental drugs
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)

# $100 Eyewear Benefit

## Biennial Benefit

Keystone HEALTH PLAN EAST

The Keystone Health Plan East $100 HMO/POS Vision Rider program, administered by Davis Vision, offers members corrective eyewear, including eyeglasses or contact lenses. The vision rider program is easy to use. Benefits are maximized by using Davis Vision providers that are conveniently located throughout the area. Paid-in-full benefits for eyeglasses with standard lenses are possible when you choose from a select grouping known as the Davis Collection of Frames.

| Benefit | Coverage |
|---|---|
| **Eyeglasses, including spectacle lenses and frames, at participating providers** | |
| Spectacle lenses | Spectacle lenses covered at no extra cost include: all range of prescriptions, oversize lenses, glass or plastic lenses, single vision, bifocal, trifocal or lenticular lenses |
| Additional lens options | Additional spectacle lens options covered at no cost include: glass grey #3 prescription sunglass lenses, tinting, polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters |
| Frames<br>**Two options** are available for selecting frames: | Choose from participating provider's own frame collection and member receives allowance of $65[1]<br>OR<br>Choose from the Davis Collection of Frames that is available at most participating providers and frames are covered in full. |
| **Eyeglasses including spectacle lenses and frames at non-participating providers** | Eyeglasses (spectacle lenses and frames) are available up to a $100 reimbursement to member[2] |
| **Contact lenses (in lieu of eyeglasses) including standard, specialty and disposable lenses and evaluation and fitting** | |
| Participating providers | Member receives allowance up to $100[1] |
| Non-participating providers | Up to $100 reimbursement to member[2] |
| **Total Out-of-Pocket Maximum** | Please refer to your Medical Coverage Benefits at a Glance for information about out-of-pocket maximum values. Out-of-pocket maximum includes applicable copayments, coinsurance and deductibles. Your out-of-pocket maximum is a combined maximum of medical, prescription drug and any included pediatric vision and pediatric dental benefits as defined by your benefit plan. |
| **Benefit frequency** | Once every two calendar years |
| **Network** | Davis Vision Network<br>To locate a participating provider, go to www.ibx.com and click on the 'Find a Doctor' feature. |

1 Member is responsible for balance

2 In lieu of participating provider benefit, member is responsible for balance

This summary is intended to highlight the benefits available to you. For a complete description, including benefits and exclusions, refer to your benefit booklet.

Administered by:

DAVISVISION

SEE LIFE



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## Value-added Services*

Spectacle lens options available at most participating providers, MEMBER PAYS fixed discounted prices:

| Spectacle Lens Option | Fixed Discounted Price |
|---|---|
| Blended invisible bifocals | $10 |
| Ultraviolet (UV) coating | $12 |
| Scratch-resistant coating - single vision | $15 |
| Scratch-resistant coating - multifocal | $25 |
| Intermediate vision lenses | $30 |
| Anti-reflective coating - standard | $33 |
| Anti-reflective coating - premium | $48 |
| Anti-reflective coating - ultra | $60 |
| Progressive additional multifocal lenses - standard | $50 |
| Progressive additional multifocal lenses - premium | $90 |
| Polarized lenses | $60 |
| Polycarbonate[3] | $30 |
| High index | $55 |
| Photochromic glass - single vision | $15 |
| Photochromic glass - multifocal | $25 |
| Photochromic plastic - single vision | $60 |
| Photochromic plastic - multifocal | $70 |

**Warranty** - Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

**Replacement Contact Lenses** - Through Lens 123, a free mail order program, member may receive replacement contact lenses offered at guaranteed, discounted prices.

**Laser Vision Correction Services** - Discount on Laser Vision Correction Services at Davis Vision Participating Laser Vision Correction Providers: Up to 25% off the participating provider's usual and customary fees or 5% off any participating provider's advertised specials, whichever is less.

**Additional Eyewear Discount** - Members selecting non-covered materials (i.e., second pair of eyeglasses, sunglasses, etc.) will receive up to a 20% courtesy discount and up to a 10% discount on disposable contacts at most participating providers.

* Not available at non-participating providers

3 Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions greater than or equal to +/- 6.00 diopters are covered at no cost.

# Frequently Asked Questions

Below find answers to some frequently asked questions about how your IBC Vision benefit program works.

### Who are the participating providers in the IBC Vision network?

Our administrator, Davis Vision, contracts with a national network of providers including ophthalmologists, optometrists and opticians. They are primarily licensed providers in private practice and in some retail locations, such as Wal-Mart Vision Center and For Eyes. Please go to www.ibx.com to locate a participating 'Vision Provider' through the 'Find a Doctor' feature, or once enrolled, call the number on your Identification card.

### If a retail location such as Wal-Mart Vision Center is in the network, does that mean the doctor located in that store is in the network?

No. When going to a retail location such as Wal-Mart Vision Center for eyewear purchases, you should always confirm the participation status of the on-site doctor who provides the eye exam, since each provider contracts separately with Davis Vision. Please Note: Coverage for routine eye exam, if available, would be included under your medical benefit.

### What are the advantages of using a participating provider?

- Quality service standards: all participating providers have been extensively reviewed and credentialed to NCQA standards to ensure that stringent standards for quality service are maintained.
- Paid-in-full benefit available: in addition to their own selection of frames, most participating providers have available the Davis Collection of Frames. This allows you to utilize the paid-in-full benefit available through your IBC Vision Program when frames are selected from the Collection with standard lenses - single, bifocal, trifocal or lenticular.
- Spectacle lens options discount: additional services such as anti-reflective coating and Transitions® lenses (photochromic) are available at a discounted price.
- Eyewear quality and value: most eyewear (lenses, coatings, and frames) is fabricated on site at one of Davis Vision's Regional Fabrication Centers. This allows Davis to monitor quality assurance and costs associated with the fabrication process, thereby creating the most value for you, our member.
- Warranty: Unconditional one-year breakage warranty to repair or replace frames or lenses purchased at a participating provider for a period of one year. This warranty applies to all spectacle lenses, Davis Vision Collection of Frames and regional/national retailer frames, when the Collection is not available.

### Will I need a claim form to receive services from a participating provider?

No, you will not need a claim form for in-network services. The process is simple. Here's what to do:

- Call the participating provider of your choice and schedule an appointment.
- Identify yourself as a member of IBC Vision, administered by Davis Vision.
- Provide the office with your ID number located on your Identification card and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and no claim forms are required!

### Will I be able to choose any frame available at a participating provider?

Yes, you may apply the amount of your frame benefit toward any available frame that you choose. You can maximize your benefit by selecting frames from the Davis Collection of Frames, which offers you the ability to have a paid in full pair of frames. The Collection is available at most participating providers. The 'Find a Doctor' feature on www.ibx.com also indicates the participating doctors that have the Davis Collection of Frames available.

### What types of frames are included in the Davis Collection of Frames?

The Davis Collection includes frames for men and women, adults and children. The collection includes many notable designer name frames that have passed rigorous inspections, such as Perry Ellis, Steve Madden, Alfred Sung, Converse, Bongo, Club Med, Catherine Deneuve, Scooby-Doo!, Garfield and Harley-Davidson. This frame collection is typically updated twice a year.

### How soon will I receive my glasses after they are ordered?

Your provider will advise you when to return to his/her office to pick up your new prescription eyeglasses. Delivery of your new eyeglasses to your participating provider from the fabrication center is generally within two to five business days of the doctor's submission of your order. More delivery time may be needed when out-of-stock frames, ARC (anti-reflective coatings), specialized prescriptions or a participating provider's frame is selected.

### What if my vision care provider does not participate in the network?

You may receive covered services from a non-participating provider, although you can receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose a non-participating provider, you pay the provider directly for all charges and then submit a Direct Reimbursement Claim Form. Covered services will be paid directly to you based on your out-of-network benefits. You are responsible for any balances.

### Where do I send the Direct Reimbursement Claim Form?

Mail your completed Direct Reimbursement Claim Form with receipts attached to:

Vision Care Processing Unit

P. O. Box 1525

Latham, NY 12110

To obtain a claim form, please visit www.ibx.com and click on 'Forms'. The IBC Vision Direct Reimbursement Claim Form is located on this Forms page under the Claims section.

### How do I purchase replacement contact lenses through the Lens 123 Program?

Enrolled members who have utilized their covered benefit may call 1-800-LENS 123 (1-800-536-7123) to register and set up your Lens 123 account. The Customer Service Representative will explain to you how to order replacement contact lenses and receive them in the mail. Lens 123 is an easy and convenient way to order replacement contact lenses. For additional information, go to www.lens123.com.