Plan Overview

2016 Health Plans for 51-99 employees

Independence

Blue Solutions Plus

Blue Solutions Plus makes selecting benefits simple

You're faced with tough decisions every day, and choosing a health care plan for your employees shouldn't be one of them.

Blue Solutions Plus makes it easy to select benefits. You control how much you spend each month by making two basic decisions:

1. How much will your employees pay when they visit a doctor or go to the hospital?
2. How much flexibility will your employees have when they use health care services?

You'll find answers to these questions and learn more about the types of health plans available in the Blue Solutions Plus suite of products.

Cost-sharing options

We offer four different types of plans in the Blue Solutions Plus portfolio — copay, deductible, health reimbursement account (HRA), and health savings account (HSA). All plans offer comprehensive coverage and comply with applicable health care reform requirements, including 100 percent coverage for certain designated preventive care services, benefits for dependents up to age 26, and no annual or lifetime dollar maximums on all essential benefits.

Use the chart below to determine which type of plan is best for your business and employees.

	COPAY PLANS[1]	DEDUCTIBLE PLANS[2]	HRA[3] AND HSA PLANS[4]
Office visits	Copay	Copay	Coinsurance after deductible
Preventive care	100% covered	100% covered	100% covered
Emergency care	Copay	Coinsurance or copay after deductible	Coinsurance after deductible
Inpatient hospital	Copay	Coinsurance or copay after deductible	Coinsurance after deductible
X-ray	Copay	Coinsurance or copay after deductible	Coinsurance after deductible
Laboratory	100% covered	100% covered (POS/DPOS) Coinsurance or copay after deductible (PPO)	Coinsurance after deductible
Prescription drugs	Yes	Yes	Yes
Pair with a tax-advantaged spending account	N/A	N/A	Yes

Cost-sharing included in the chart above applies to in-network coverage only. For out-of-network cost-sharing, refer to the benefits summary charts.

1 POS Plus 1B-4B, DPOS Plus1B-3B, PPO Plus 1B-4B.

2 POS Plus 5B-7B, DPOS Plus4B-6B, PPO Plus 5B-10B.

3 HRA Plus 1B-3B.

4 HDHP Plus 1B-5B.

Employer advantages of an HRA:

- Contributions are tax deductible
- Provides employees with a means to pay for higher deductible amounts
- Unused funds remain with the employer; employees may have access to the unused funds, at the employer's discretion, subject to COBRA

Employee advantages of an HSA:

- Funds may be carried over each year
- Employer contributions are generally excluded from employee's gross income and not taxable
- Distributions for qualified medical expenses are generally not taxable

The difference between our plans is what your employees pay when they see a doctor or go to the hospital. With our copay plans, your employees will pay a fixed dollar amount for most services while our deductible, HRA, and HSA plans help reduce costs by requiring a deductible and cost sharing for certain services.

Copay plans

Copay plans offer predictability. Most in-network services employees typically use are covered by a fixed dollar amount.

Whether going to the doctor, seeing a physical therapist, or taking a trip to the emergency room, your employees pay their copay and we take care of the rest when they use a participating provider.

Deductible plans

With our affordable deductible plans, employees still have copays for the medical care they use most and 100 percent coverage for certain preventive services. The deductible, an amount employees pay before insurance kicks in, applies only to services such as hospital and emergency care. Once the deductible is met, employees are responsible for coinsurance only.

HRA plans

HRAs provide employers and employees with flexibility. If you wish to fund HRAs, you determine what medical expenses and services are eligible for reimbursement. You receive tax advantages for providing your employees with a way to save on medical expenses, and you may retain any funds left in an HRA when an employee leaves the company.

Since you fund HRAs throughout the year, you won't have to set aside money up front, giving you greater flexibility in how you manage your cash flow. You open the HRA account by depositing a portion of your total contribution and add to the account throughout the year as employees use their funds.

HSA plans

When you offer a Personal Choice HSA plan, your employees are eligible to open a tax-advantaged HSA. Contributions to HSAs may be made by employers, employees, or a combination of both. Either way there are tax advantages for both you and your employees:

- Employee contributions reduce their taxable income
- Interest earned is tax-free when spent on qualified medical expenses
- Qualified medical expenses reimbursed from the account are tax-free

Tax advantages make HSAs a great way to save. And since HSA savings can be used to pay for deductibles and coinsurance, they may help offset increased employee costs.

Product options

How much flexibility do you want to give your employees when they receive health care services?

- Personal Choice® PPO plans provide the ultimate in flexibility. Your employees get in-network coverage across the country when using participating BlueCard® PPO providers plus coverage out-of-network. Plus, your employees won't need referrals to visit specialists.
- Keystone Direct POS provides out-of-network coverage, but your employees select a primary care physician (PCP) and need referrals for certain services, which helps keep costs down.[1]
- Keystone POS plans require employees to select a PCP to coordinate all of their care with network providers, but they also have the option to seek care from out-of-network providers.

Take a look at how the plans compare.

	KEYSTONE POS	KEYSTONE DIRECT POS	PERSONAL CHOICE
Access to network of more than 60,000 physicians and specialists	X	X	X
Selection of a PCP required	X	X	
No referrals needed to visit in-network specialists		X[1]	X
In-network benefits coast-to-coast through BlueCard PPO			X
Away from Home Care® program for employees who temporarily reside outside the service area	X	X	
Emergency and urgent care access across the country and around the world through BlueCard PPO and BlueCard Worldwide	X	X	X

1. Direct POS employees need a referral from their PCP for spinal manipulations, routine X-rays, and physical/occupational therapy. For lab work, employees should use the facility recommended by their PCP for the lowest out-of-pocket costs.

Prescription drug coverage

Promoting better health

Your Blue Solutions Plus medical benefits include IBC Prescription Drug coverage. Your employees' prescription drug benefit program provides many advantages to help your employees easily and safely obtain the prescription drugs they need at an affordable cost. All Blue Solutions Plus plans are designed to incent your employees to use the most cost-effective medications available.

Convenient mail-order pharmacy

If your employee's doctor has prescribed a medication that he or she needs to take regularly over a long period of time, the mail-order service is an excellent way to get a long-lasting supply and reduce out-of-pocket costs.

Mail order is convenient and safe to use. If your employees choose mail order, their doctor can prescribe a supply that will last up to 90 days. Employees can get three times as many doses of their maintenance medication at one time through mail order.

Specialty Pharmacy Program

The Specialty Pharmacy Program is a convenient delivery system for specialty medications. Since specialty drugs require special handling, administration, and monitoring, these complex and costly medications may not be readily available at local pharmacies. With the Specialty Pharmacy Program, your employees' medications will be delivered directly to their homes or to their doctors. In addition, your employees will have 24/7 access to our clinical staff who will answer questions about specialty medications.

Pharmacy benefits are administered by FutureScripts, a Catamaran company, an independent company providing pharmacy benefit management services.

Pharmacy networks

Participating pharmacies

The FutureScripts® network includes more than 68,000 retail pharmacies. When traveling, your employees will find that most of the pharmacies in all 50 states accept their ID card and can fill their prescription for the same cost they pay at home, as long as they use a participating pharmacy. There is no need for employees to select just one pharmacy for their prescription needs. To locate a participating pharmacy, visit **www.ibx.com** and select *Find a Pharmacy*.

Non-participating pharmacies

Out-of-network benefits apply to prescriptions filled at non-participating pharmacies. Employees must pay the full retail price for their prescription, then file a paper claim for partial reimbursement.

Select Drug Program options

	OPTION 1	OPTION 2	OPTION 3	OPTION 4	OPTION 5	OPTION 6	OPTION 7
	$10/$20/$35	$10/$40/$70	$10/$45/$75	$15/$35/$50	$20/$40/$60	$250/$10/$45/$75	$250/$20/$40/$60
Deductible[1]	N/A	N/A	N/A	N/A	N/A	$250 (waived for generics)	$250
Generic formulary	$10	$10	$10	$15	$20	$0	$20
Brand formulary	$20	$40	$45	$35	$40	$45	$40
Non-formulary brand	$35	$70	$75	$50	$60	$75	$60

Basic Drug options

	OPTION 8	OPTION 9
	$7/50% ($125)	$4/brand discount
Deductible	N/A	N/A
Generic	$7	$4
Brand	50% of discounted price up to $125 (maximum member payment per prescription)	Discount available[2]

Online services

Your employees can log on to **ibxpress.com** to take advantage of convenient features, such as:

- Network pharmacy search
- Formulary search
- Claims information
- Mail-order refill requests

1. Deductible is applied per person per calendar year to all covered services purchased in network and out of network through a retail pharmacy or the mail order network.
2. Brand drugs vary in cost, and cost-sharing is based on a discounted amount that was negotiated with the pharmacy.

Solutions to help you manage your health benefits

Manage your account with ibxpress.com

Running a business means that you have a lot of responsibilities to juggle, so we make managing your health benefits as easy as possible. Whether you're looking for account information or online billing, you get 24/7 access through **ibxpress.com**.

Account Management features:

- Add or delete a employee
- Change employee or dependent information
- View coverage history
- Download forms

eBilling features:

- View current and prior invoices
- Review billing and payment history
- Get monthly billing reminders
- Receive and pay invoices online

Solutions to help your employees manage their health

Your employees can also access **ibxpress.com**, which is loaded with wellness tools and information to help your employees stay healthy. Whether they want to research symptoms, complete a health assessment, or record and track important health information, ibxpress.com can help.

Employees can use ibxpress.com to review their benefits, find a doctor or hospital, and check the status of claims. It's free, secure, and convenient.

Employees can manage their health on the go with IBX Mobile

Even if they aren't near a computer, your employees can still access their benefits. They can download the free IBX Mobile app for their iPhone or Android to help them make the most of their health plan. IBX Mobile gives your employees easy access to their health care coverage 24/7, so they can:

- View benefits and claim information
- View temporary ID card information
- View Primary Care Physician information and open referrals
- View their Personal Health Record
- Find a doctor
- Estimate the price of a drug
- Call customer service

All they have to do is log in with the same username and password they use for **ibxpress.com**.

Underwriting Guidelines

Maximum Product offerings[1]

- Groups of 51–99 enrolled contracts can select a maximum of three medical plans and up to two select drug programs including basic drug options.

Participation requirements[2]

- Groups with 51–99 eligible lives must have 75 percent participation, which includes all product lines.
- IBC will count waivers in the eligibility calculations.
- Credit is given for those eligible subscribers who opt out because they have coverage through a spouse, as an eligible dependent to 26, or is enrolled in Medicare or Medicaid. Only these types of opt-outs, or waivers, are excluded from the calculation to determine if a group meets the 75 percent participation requirement.
- Retiree-only groups will not be accepted. For groups covering retirees, 100 percent participation will be required for retired employees. The group must consist of a minimum of 75 percent active employees.

Employer contribution requirement[2]

- For contributory plan offerings, employers must contribute a minimum of 25 percent of the calculated gross monthly premium or 75 percent of the single-tier rate for each plan offered.

Off-Anniversary Benefit Changes

- Off-anniversary groups will only be allowed to downgrade.
- Downgrades will be allowed only if the effective date of the change is greater than 90 days prior to the next anniversary date.
- Customers may upgrade or downgrade their coverage upon anniversary.

Rate tiers

- A standard four-tier rating structure is required.

High deductible health plan funding limitation[2]

- For fully insured accounts that offer a high deductible health plan (HDHP), the employer cannot fund more than 50 percent of the annual deductible. Providing a secondary/supplemental product to fund the annual employee/family deductible (including the employer covering the cost of the deductible) is not permitted.

Submission guidelines

- All offerings are subject to final underwriting review and acceptance. Additional guidelines and policies may apply. This document is for informational purposes only and is not intended to be all inclusive.

1. For Blue Solutions Choice maximum product offerings and Underwriting guidelines, please refer to the 51-99 Blue Solutions Choice flyer.
2. As permitted by the state and federal legislation and mandates.

What's not covered?

The information in this brochure represents only a partial listing of benefits and exclusions of the plans. Benefits and exclusions may be further defined by medical policy. The managed care plan may not cover all of your health care expenses. Read your contract/member handbook/benefit booklet carefully to determine which health care services are covered. If you need more information please call 1-800-275-2583.

- 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 nonemployee 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 loss
- Alternative therapies/complementary medicine such as acupuncture
- 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

Benefits that require preapproval

Additional approval from Independence Blue Cross may be required before your employees may receive certain tests, procedures, and medications. When your employees need services that require preapproval, their primary care physician or provider* contacts the Care Management and Coordination (CMC) team and submits information to support the request for services. The CMC team, made up of physicians and nurses, evaluates the proposed plan of care for payment of benefits. The CMC team will notify your employee's physician/provider if the services are approved for coverage. If the CMC team does not have sufficient information or the information evaluated does not support coverage, your employee and his or her physician/provider are notified in writing of the decision. Employees or a provider acting on their behalf may appeal the decision. At any time during the evaluation process or the appeal, the provider or your employee may submit additional information to support the request.

* For a list of services that require preapproval, visit www.ibx.com/preapproval.

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