

Personal Choice

PPO 8.1 Summary of Benefits



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	Contract Year ²	Contract Year ²
DEDUCTIBLE		
Individual	\$2,000	\$5,000
Family	\$6,000	\$15,000
AFTER DEDUCTIBLE, PLAN PAYS	80%	50%
OUT-OF-POCKET MAXIMUM (includes coinsurance only)		
Individual	\$3,000	\$15,000
Family	\$9,000	\$45,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	\$30 copayment, no deductible	50%, after deductible
Specialist services	\$50 copayment, no deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, no deductible	50%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply), no deductible	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per benefit period for women of any age ³	100%, no deductible	50%, no deductible
MAMMOGRAM	100%, no deductible	50%, no deductible

1 Non-Preferred Providers may bill you the differences between the Plan allowance, which is the amount paid by Personal Choice, 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, the 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, payment is 50% of the actual charge of the provider. For services rendered by hospitals and other facility providers in the local service area, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under IBC contracts with 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. 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 contract year benefit period is a consecutive 12-month period that begins on your employers effective date. The deductible and out-of-pocket maximum amount start at \$0 at the beginning of each contract year.

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



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

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Benefit	In-network	Out-of-network ¹
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per benefit period ³	100%, no deductible	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	80%, after deductible	50%, after deductible
MATERNITY		
First OB visit	\$30 copayment, no deductible	50%, after deductible
Hospital	80%, after deductible	50%, after deductible
INPATIENT HOSPITAL SERVICES	80%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY	80%, after deductible	50%, after deductible
EMERGENCY ROOM	80%, after deductible; (not waived if admitted)	80%, after deductible; (not waived if admitted)
AMBULANCE		
Emergency	100%	100%
Non-emergency	80%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	80%, after deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	80%, after deductible	50%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per benefit period for PT/OT combined ³	\$50 copayment, no deductible	50%, after deductible
Cardiac rehabilitation 36 visits per benefit period ³	\$50 copayment, no deductible	50%, after deductible
Pulmonary rehabilitation 36 visits per benefit period ³	\$50 copayment, no deductible	50%, after deductible
Speech 20 visits per benefit period ³	\$50 copayment, no deductible	50%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum ³	\$50 copayment, no deductible	50%, after deductible
SPINAL MANIPULATIONS 20 visits per benefit period ³	\$50 copayment, no deductible	50%, after deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%, no deductible	50%, after deductible
Biotech/Specialty Injectables	\$100 copayment, no deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	80%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per benefit period ³	80%, after deductible	50%, after deductible
SKILLED NURSING FACILITY 120 days per benefit period ³	80%, after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE	80%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%, after deductible	50%, after deductible
PROSTHETICS	50%, after deductible	50%, after deductible
MENTAL HEALTH CARE		
Outpatient 20 visits per benefit period ³	\$50 copayment, no deductible	50%, after deductible
Inpatient 30 days per benefit period ³	80%, after deductible	50%, after deductible, up to 20 days per benefit period

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SERIOUS MENTAL ILLNESS CARE		
Outpatient 60 visits per benefit period ²	\$50 copayment, no deductible	50%, after deductible
Inpatient 30 days per benefit period ³	80%, after deductible	50%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits 60 visits per benefit period ² , 120 visits lifetime maximum ³	\$50 copayment, no deductible	50%, after deductible
Rehabilitation 30 days per benefit period ³ , 90 day lifetime maximum ³	80%, after deductible	50%, after deductible
Detoxification 7 days per admission ³ , 4 admissions lifetime maximum ³	80%, after deductible	50%, after deductible

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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
- contraceptives
- 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 benefits booklet 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).

Services that require precertification

INPATIENT SERVICES

Surgical and nonsurgical inpatient admissions
Acute rehabilitation
Skilled nursing facility
Inpatient hospice

OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

MRI/MRA
CT/CTA scan
PET scan
Nuclear cardiac studies
Hyperbaric Oxygen
Hysterectomy
Cataract surgery
Cochlear implant surgery
Nasal surgery for submucous resection and septoplasty
Transplants (except cornea)
Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
Obesity surgery
Day rehabilitation programs
Dental services as a result of accidental injury
Uvulopalatopharyngoplasty (including laser-assisted)

ALL HOME CARE SERVICES (including infusion therapy in the home)

INFUSION THERAPY DRUGS

Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)

MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS

Purchase items (including repairs and replacements) over \$500 (excluding ostomy supplies)

DURABLE MEDICAL EQUIPMENT

Purchase items (including repairs and replacements) over \$500, and ALL rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES

Blepharoplasty/ptosis repair
Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
Canthopexy/canthoplasty
Cervicoplasty
Chemical peels
Dermabrasion
Excision of excessive skin and/or subcutaneous tissue
Genetically and bio-engineered skin substitutes for wound care
Hair transplant
Injectable dermal fillers
Keloid removal
Labioplasty
Lipectomy, Liposuction, or any other excess fat removal procedure
Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
Otoplasty
Rhinoplasty
Rhytidectomy
Scar revision
Skin closures, including skin grafts, skin flaps, tissue grafts
Sex reassignment surgery
Surgical treatment of gynecomastia
Surgery for varicose veins, including perforators and sclerotherapy

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

Mental health and serious mental illness treatment (Inpatient/partial hospitalization programs/intensive outpatient programs)
Substance abuse treatment (Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS

(See list included in your open enrollment packet)

Personal Choice® network providers will obtain precertification for you if it is required. You are not required to obtain precertification when treated in a Personal Choice network hospital or facility or by a Personal Choice network physician. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain precertification.

If the provider is a BlueCard® PPO provider of another Blue Plan or you use an out-of-network provider, you must obtain precertification if required. You may be subject to a 20% reduction in benefits if precertification is not obtained.

In addition to the precertification requirements listed above, you should contact Independence Blue Cross and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by BlueCard providers, or out-of-network providers. The categories of treatment (in any setting) include

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents new or emerging technology; and
- Services that might be considered experimental/investigative.

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

Precertification is not a determination of eligibility or a guarantee of payment. Coverage and payment are contingent upon, among other things, the patient being eligible, i.e., actively enrolled in the health benefits plan when the precertification is issued and when approved services occur. Coverage and payment are also subject to limitations, exclusions, and other specific terms of the health benefits plan that apply to the coverage request.