Personal Choice

Personal Choice 15/25/70 Summary of Benefits

AFSCME District Council 47 Modified

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 care through Personal Choice's expansive 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*
Deductible		
Individual	$0	$500
Family	$0	$1,000
After Deductible, Plan Pays	100%	70%
Out-of-Pocket Maximum		
Individual	None	$3,000
Family	None	$6,000
Lifetime Maximum (includes psychiatric services)	Unlimited	$1 Million
Doctor's Office Visits		
Primary Care Services	$15 Copayment	70%, after deductible
Specialist Services	$25 Copayment	70%, after deductible

* Out-of-network, non-participating providers may bill you for differences between the Plan allowance, which is the amount paid by Personal Choice, and the provider's actual charge. This amount may be significant. Claims payments for out-of-network professional providers (physicians) are based on IBC's own fee schedule. For services rendered by hospitals and other facility providers, the allowance may not refer to the actual amount paid by Personal Choice to the provider. Under Independence Blue Cross (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 provider's actual charge.**

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*
PREVENTIVE CARE FOR ADULTS AND CHILDREN	$15 Copayment	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100%	70%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	100%	70%, NO deductible
MAMMOGRAM	100%	70%, NO deductible
MATERNITY		
First OB visit	$15 Copayment	70%, after deductible
Hospital	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible
INPATIENT HOSPITAL SERVICES	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible
INPATIENT HOSPITAL DAYS	365	70
OUTPATIENT SURGERY	Covered 100% ~~$100 Copayment~~	70%, after deductible
EMERGENCY ROOM	$40 Copayment (waived if admitted)	$40 Copayment (waived if admitted)
OUTPATIENT LABORATORY	100%	70%, after deductible
OUTPATIENT RADIOLOGY	$25 Copayment	70%, after deductible
THERAPY SERVICES		
Physical, Speech and Occupational (60 visits per calendar year)	$15 Copayment [visits 1-30] $25 Copayment [visits 31-60]	70%, after deductible 70%, after deductible
Cardiac Rehabilitation (36 visits per calendar year)	$15 Copayment	70%, after deductible
Pulmonary Rehabilitation (12 visits per calendar year)	$15 Copayment	70%, after deductible
Respiratory Therapy	$15 Copayment	70%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 VISITS PER CALENDAR YEAR)	$25 Copayment	70%, after deductible
CHEMO/RADIATION AND RENAL DIALYSIS THERAPY	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING (360 HOURS PER CALENDAR YEAR)	100%	70%, after deductible
SKILLED NURSING CARE (120 DAYS PER CALENDAR YEAR)	100%	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible

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Benefit	In-Network	Out-of-Network*
Durable Medical Equipment and Prosthetics	$25 Copayment	70%, after deductible
Outpatient Diabetic Education	100%	Not covered
Outpatient Psychiatric		
30 visit maximum per calendar year, combination of in/out-of-network	$25 Copayment	50%, after deductible up to 20 visits per calendar year
Inpatient Psychiatric		
30 day maximum per calendar year, combination of in/out-of-network	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible up to 20 days per calendar year
Serious Mental Illness Care		
Outpatient 60 day maximum per calendar year, combination of in/out-of-network	$25 Copayment	50%, after deductible
Inpatient 30 day maximum per calendar year, combination of in/out-of-network	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible
Substance Abuse Treatment		
Outpatient/Partial Facility Visits 30 visits per calendar year	100%	70%, after deductible
Rehabilitation 30 days per calendar year	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible
Detoxification 7 days per admission	Covered 100% ~~$100 per day (up to $500 maximum per admission)~~	70%, after deductible

Lifetime limits also apply to Substance Abuse Treatment

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What Is Not Covered?**

- Services determined not to be medically necessary or medically appropriate
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service or supply
- Cosmetic services, supplies or treatment
- Routine foot care
- Supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- Dental and vision care (except as specified in a group contract)
- Military or occupational injuries or illness
- Maintenance of chronic conditions when treatment has reached maximum therapeutic value
- Benefits payable by the government, Medicare or through motor vehicle insurance
- Assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT (except as specified in a group contract)
- Charges in excess of benefit maximums or allowable charges as set forth in the group contract
- Experimental or investigative services
- Inpatient private duty nursing
- Acupuncture
- Hearing aids and hearing examinations for the prescription of hearing aids
- Immunizations required for employment or travel

**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 1-800-626-8144 (outside Philadelphia) or 215-557-7577 (if calling within the Philadelphia area).

Services That Require Pre-Authorization

Service	In-Network (Personal Choice® network provider or BlueCard® PPO provider)	Out-of-Network
All Non-Emergency Inpatient Admissions (except Maternity Admissions)	Required	Required
Outpatient Surgical Procedures		
Bunionectomy	Required	Required
Cataract Surgery	NOT Required	Required
Laparoscopic Cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia Repair	NOT Required	Required
Arthroscopic Knee Surgery/Diagnostic Arthroscopy	Required	Required
Ligation and Stripping of Varicose Veins	Required	Required
Prostate Surgery	NOT Required	Required
Spinal/Vertebral Surgery	NOT Required	Required
Submucous Resection (nasal surgery)	Required	Required
Tonsillectomy and/or Adenoidectomy	Required	Required
Transplants	Required	Required
Operative and Diagnostic Endoscopies	NOT Required	Required
MRI	NOT Required	Required
CAT Scan	NOT Required	Required
Outpatient Therapies: Physical, Speech, Occupational, Cardiac, Pulmonary, Respiratory, Infusion	Required Required	Required Required
Restorative Services, including chiropractic care and related services	Required	Required
Outpatient Private Duty Nursing	Required	Required
Other Facility Services: Skilled Nursing, Hospice, Home Health, Birth Center	Required Required	Required Required
Psychiatric, Substance Abuse and Serious Mental Illness Treatment		
Inpatient	Required	Required
Outpatient and Partial Facility	Required	NOT Required
Non-Emergency Ambulance	Required	Required
Rental of Durable Medical Equipment	Required	Required
Purchase of Durable Medical Equipment Over $100	Required	Required
Prosthetics	Required	Required

Personal Choice network providers will obtain pre-authorization for you, if it is required for the service provided. You are not required to obtain pre-authorization when you are treated in a Personal Choice network hospital or facility, or by a Personal Choice network doctor. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain prior approval.

If you use a provider who is a BlueCard PPO network provider, or an out-of-network provider, you must obtain pre-authorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain pre-authorization.

Call Independence Blue Cross at the pre-authorization telephone number listed on the back of your identification card to initiate pre-authorization.

You may be responsible for financial penalties if you do not pre-authorize services when you use a BlueCard PPO provider, or an out-of-network provider. There is a $1,000 penalty for failure to pre-authorize inpatient services or treatment, and a 20% reduction in benefits for failure to pre-authorize outpatient services or treatment. Additionally, a 50% reduction in benefits may apply for failure to pre-authorize restorative services (including chiropractic care), physical therapy, speech therapy and occupational therapy.

Pre-authorization 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 pre-authorization 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.