

Personal Choice

Personal Choice 210 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 care through Personal Choice's expansive network of hospitals, doctors and specialists, or by accessing care through preferred providers that participate in the Blue Card 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 Family	\$200 \$400	\$500 \$1000
AFTER DEDUCTIBLE, PLAN PAYS	100%	80%
OUT-OF-POCKET MAXIMUM Individual Family	None None	\$3,000 \$6,000
LIFETIME MAXIMUM (includes psychiatric services)	Unlimited	\$1 Million
DOCTOR'S OFFICE VISITS Primary Care Services Specialist Services	\$10 copay NO deductible \$10 copay NO deductible	80%, after deductible 80%, after deductible

* Out-of-network providers may also balance bill for differences between the Plan allowance and their actual charge.

To find a Personal Choice network doctor or specialist, call the Health Resource Center at 1-800-ASK-BLUE or visit the independence Blue Cross website at www.ibx.com

To find BlueCard PPO network providers, call BlueCard Access at 1-800-810-2583, or visit the BlueCard Doctor and Hospital Finder website at www.bcbs.com and select PPO Network

Questions? Please call the Member Services telephone number on the back of your identification card.



**Independence
Blue Cross**

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

Benefit	In-Network	Out-Of-Network*
PREVENTIVE CARE FOR ADULTS AND CHILDREN	\$10 copay, NO deductible	80%, after deductible
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	80%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age	100%, NO deductible	80%, NO deductible
ROUTINE MAMMOGRAM 1 per calendar year for women age 40 and older	100%, NO deductible	80%, NO deductible
MATERNITY First OB visit Hospital	\$10 Copayment, No deductible 100%, after deductible	80%, after deductible 80%, after deductible
INPATIENT HOSPITAL SERVICES	100%, after deductible	80%, after deductible
INPATIENT HOSPITAL DAYS	365	70
OUTPATIENT SURGERY	100%, after deductible	80%, after deductible
EMERGENCY ROOM	\$25 copay (waived if admitted) NO deductible	\$25 copay (waived if admitted) NO deductible
OUTPATIENT LABORATORY	100%, NO deductible	80%, after deductible
OUTPATIENT RADIOLOGY	100%, after deductible	80%, after deductible
THERAPY SERVICES Physical, Speech and Occupational Cardiac Rehabilitation (18 visits/calendar year) Pulmonary Rehabilitation (12 visits/calendar year) Respiratory Therapy	\$15 copay, NO deductible \$15 copay, NO deductible \$15 copay, NO deductible \$15 copay, NO deductible	80%, after deductible 80%, after deductible 80%, after deductible 80%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE	\$15 copay, NO deductible	80%, after deductible
CHEMO/RADIATION AND RENAL DIALYSIS THERAPY	100%, after deductible	80%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	100%, after deductible	80%, after deductible
SKILLED NURSING CARE	100%, after deductible	80%, after deductible
HOSPICE AND HOME HEALTH CARE	100%, after deductible	80%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	100%, after deductible	80%, after deductible

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Benefit	In-Network	Out-Of-Network*
OUTPATIENT DIABETIC EDUCATION	100%, NO deductible	Not covered
OUTPATIENT PSYCHIATRIC 30 visit maximum per calendar year, combination of in/out-of-network	Visits 1-9, \$10 copayment Visits 10 -30,20 copayment 0 deductible	50%, after deductible up to 20 visits per calendar year
INPATIENT PSYCHIATRIC 30 day maximum per calendar year, combination of in/out-of-network	100%, after deductible	80%, 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 Inpatient 30 day maximum per calendar year, combination of in/out-of-network	Visits 1-9, \$10 copayment Visits 10+: \$20 Copayment NO deductible 100%, after deductible	50%, after deductible 80%, after deductible
SUBSTANCE ABUSE TREATMENT Outpatient/Partial Facility Visits 30 visits/calendar year Rehabilitation 30 days/calendar year Detoxification 7 days/admission <i>Lifetime limits also apply to Substance Abuse Treatment</i>	100%, after deductible 100%, after deductible 100%, after deductible	80%, after deductible 80%, after deductible 80%, after deductible

* Out-of-network providers may also balance bill for differences between the Plan allowance and their actual charge.

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
- Benefits payable by the government, Medicare or through motor vehicle insurance
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- 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

**For a complete list of benefits, limitations and exclusions, please see your group contract.

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 <ul style="list-style-type: none"> • Bunionectomy • Cataract Surgery • Laparoscopic Cholecystectomy • Hemorrhoidectomy • Hernia Repair • Arthroscopic Knee Surgery • Diagnostic Arthroscopy • Ligation and Stripping of Varicose Veins • Prostate Surgery • Spinal/Vertebral Surgery • Submucous Resection (nasal surgery) • Tonsillectomy and/or Adenoidectomy 	Required NOT Required Required Required NOT Required Required Required Required NOT Required NOT Required Required Required	Required Required Required Required Required Required Required Required Required Required Required Required
TRANSPLANTS	Required	Required
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES MRI CAT SCAN	NOT Required NOT Required NOT Required	Required 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 Outpatient and Partial Facility	Required Required	Required NOT Required
NON-EMERGENCY AMBULANCE	Required	Required
RENTAL OF DURABLE MEDICAL EQUIPMENT PURCHASE OF DURABLE MEDICAL EQUIPMENT OVER \$100 PROSTHETICS	Required Required Required	Required 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 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.