Personal Choice

PHO

Drexel U.- Basic Option

Personal Choice® pur 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 large 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

Benefits	In-Network Tenet Preferred	Personal Choice Network	Out-of-Network Out-of-Network
DEDUCTIBLE			
Individual	$0	$300	$750
Family	$0	$600	$1,500
COINSURANCE	100%, unless noted	90%, unless noted	70%, unless noted
OUT-OF-POCKET MAXIMUM (Deductibles, copayments, and coinsurance amounts apply to maximum)			
Individual*	$1,000	$1,000	$3,000
Family*	$2,000	$2,000	$6,000
LIFETIME MAXIMUM	Unlimited	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS			
Primary Care Services	$0 copayment	$20 copayment, no deductible	70%, after deductible
Specialist Services	$10 copayment	$30 copayment, no deductible	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	100%, no deductible	70%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	100% (office visit copayment does not apply) no deductible	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 routine exam/pap test per calendar year for women of any age[3]	100%	100%, no deductible	70%, no deductible
MAMMOGRAM	100%	100%, no deductible	70%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year[3]	100%	100%, no deductible	70%, after deductible
ALLERGY INJECTIONS (office visit copayment waived if no office visit is charged)	100%	100%, no deductible	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	100%, no deductible	70%, after deductible
MATERNITY			
First OB Visit	$10 copayment	$20 copayment, no deductible	70%, after deductible
Hospital	100%	90%, after deductible	70%, after deductible[4]

3 Combined all tiers

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

* Combined Tenet Prefered and Personal Choice in-network

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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Benefits	In-Network Tenet Preferred	Personal Choice Network	Out-of-Network Out-of-Network
INPATIENT HOSPITAL SERVICES			
Facility	100%	90%, after deductible	70%, after deductible[4]
Physician/Surgeon	100%	90%, after deductible	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	Unlimited	70[4]
OUTPATIENT SURGERY			
Facility	100%	90%, after deductible	70%, after deductible
Physician/Surgeon	100%	90%, after deductible	70%, after deductible
EMERGENCY ROOM (copayment waived if admitted)	$75 copayment	$75 copayment, no deductible	$75 copayment, no deductible
URGENT CARE CENTER	100% at St. Chris Pediatric Urgent Care	$35 copayment, no deductible	70%, after deductible
AMBULANCE			
Emergency	100%	90%, after deductible	90%, after in-network deductible
Non-Emergency	100%	90%, after deductible	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY (Copayment not applicable when service performed in ER or office setting)			
Routine Radiology/Diagnostic	100%	90%, after deductible	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%	90%, after deductible	70%, after deductible
THERAPY SERVICES			
Physical and Occupational 60 visits maximum per calendar year combined for PT, OT and Speech[3]	Provider is only available in Personal Choice Network	$30 copayment, no deductible	70%, after deductible
Cardiac Rehabilitation 36 visits maximum per calendar year[3]	100%	$30 copayment, no deductible	70%, after deductible
Pulmonary Rehabilitation 12 visits maximum per calendar year[3]	100%	$30 copayment, no deductible	70%, after deductible
Speech 60 visits maximum per calendar year combined for PT, OT and Speech[3]	100%	$30 copayment, no deductible	70%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[3]	100%	$30 copayment, no deductible	70%, after deductible
SPINAL MANIPULATIONS, including CHIROPRACTIC CARE 30 visits per calendar year[3]	Provider is only available in Personal Choice Network	$30 copayment, no deductible	70%, after deductible
INJECTABLE MEDICATIONS			
Standard Injectables[2]	100%	100%, NO deductible	70%, after deductible
Biotech/Specialty Injectables	$0 copayment	$0 copayment	70%, after deductible
CHEMO/RADIATION	100%	90%, after deductible	70%, after deductible
DIALYSIS	100%	90%, after deductible	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours maximum per calendar year[3]	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible
SKILLED NURSING FACILITY 120 days maximum per calendar year[3]	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible
HOME HEALTH CARE	100%	90%, after deductible	70%, after deductible
HOSPICE	100%	90%, after deductible	70%, after deductible
DURABLE MEDICAL EQUIPMENT	Provider is only available in Personal Choice Network	90%, after deductible	70%. after deductible
PROSTHETICS	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	100%, no deductible	Not covered
MENTAL HEALTH CARE			
Outpatient	Provider is only available in Personal Choice Network	$30 copayment, no deductible	70%, after deductible
Inpatient	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible[4]
SERIOUS MENTAL ILLNESS			
Outpatient	Provider is only available in Personal Choice Network	$30 copayment, no deductible	70%, after deductible
Inpatient	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible[4]

2 Office visit subject to copayment

3 Combined all tiers

4 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.

Benefits	In-Network Tenet Preferred	Personal Choice Network	Out-of-Network Out-of-Network
ALCOHOL AND DRUG ABUSE TREATMENT			
Detoxification	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible[4]
Outpatient/Partial Services	Provider is only available in Personal Choice Network	$30 copayment, no deductible	70%, after deductible
Inpatient Rehabilitation	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible[4]

4 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.

What Is Not Covered?

- Services not medically necessary
- Services or supplies which are experimental or investigative except routine costs associated with clinical trials
- 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 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
- Routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- Immunizations for travel or employment
- Service or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- Cosmetic services/supplies
- Vision care (except as specified in a group contract)
- Self-injectable drugs

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
Hyperbaric Oxygen	Required	Required
Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)	Required	Required
OUTPATIENT SURGICAL PROCEDURES		
Bunionectomy	Required	Required
Cataract surgery	Required	Required
Cochlear implant surgery	Required	Required
Laparoscopic cholecystectomy	Required	Required
Hemorrhoidectomy	Required	Required
Hernia repair	Not Required	Required
Arthroscopic knee surgery/diagnostic arthroscopy	Required	Required
Obesity surgery	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
RECONSTRUCTIVE PROCEDURES AND POTENTIALLY COSMETIC PROCEDURES (for a complete list of these procedures, please see Benefits that Require preauthorization available on ibx.com)	Required	Required
Surgery for varicose veins, including perforators and sclerotherapy	Required	Required
Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies	Required	Required
TRANSPLANTS	Required	Required
OPERATIVE AND DIAGNOSTIC ENDOSCOPIES	Not Required	Required
MRI/MRA	Required	Required
CT/CTA SCAN	Required	Required
PET SCAN	Required	Required
NUCLEAR CARDIAC STUDIES	Required	Required
OUTPATIENT THERAPIES: Speech	Required	Required
OUTPATIENT PRIVATE DUTY NURSING	Required	Required
OTHER FACILITY SERVICES: Skilled nursing, Inpatient hospice, Home health, Birth center	Required	Required
MENTAL HEALTH, SUBSTANCE ABUSE, AND SERIOUS MENTAL ILLNESS TREATMENT		
Inpatient	Required	Required
Partial hospitalization programs/Intensive outpatient programs	Required	Required
DAY REHABILITATION PROGRAMS	Required	Required
DENTAL SERVICES AS A RESULT OF ACCIDENTAL INJURY	Required	Required
NON-EMERGENCY AMBULANCE	Required	Required
DURABLE MEDICAL EQUIPMENT Purchase items (including repairs and replacements) over $500, and ALL rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)	Required	Required
PROSTHETICS AND ORTHOTICS Purchase items (including repairs and replacements) over $500 (except ostomy supplies)	Required	Required
INFUSION THERAPY IN A HOME SETTING	Required	Required
INFUSION THERAPY DRUGS Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)	Required	Required

Personal Choice® network providers will obtain preauthorization for you, if it is required for the service provided. You are not required to obtain preauthorization 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 you use an out-of-network provider, you must obtain preauthorization if required for the service or supply being provided. You may be subject to financial penalties if you do not obtain preauthorization.

Call Independence Blue Cross at the preauthorization telephone number on your identification card to initiate preauthorization.

You may be responsible for financial penalties if you do not preauthorize services when you use a BlueCard PPO provider, or an out-of-network provider. There is a $1,000 penalty for failure to preauthorize inpatient services or treatment, and a 20% reduction in benefits for failure to preauthorize outpatient services or treatment.

Preauthorization 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 preauthorization 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.