Personal Choice

PPO $30-$60/$400

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	$0	$2,500
Family	$0	$5,000
OUT-OF-POCKET MAXIMUM[3]		
Individual	$7,350	$10,000
Family	$14,700	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$30 copayment	50%, after deductible
Specialist services	$60 copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, no deductible
PEDIATRIC IMMUNIZATIONS	100%	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[4]	100%	50%, no deductible
MAMMOGRAM	100%	50%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[4]	100%	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible

1 Non-Preferred Providers may bill you for differences between the Plan allowance, which is the amount paid by Independence Blue Cross (IBC), 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, 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, the payment is based on 50% of the actual charge of the provider. 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.

2 A contract year benefit period is a consecutive 12-month period that begins on your employer's effective date. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each contract year.

3 In-network out-of-pocket maximum includes the copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

4 Combined in/out-of-network

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

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Benefit	In-network	Out-of-network[1]
MATERNITY		
First OB visit	100%	50%, after deductible
Hospital	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]
INPATIENT HOSPITAL SERVICES		
Facility	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]
Physician/Surgeon	100%	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[6]
OUTPATIENT SURGERY		
Facility	$400 copayment	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	$300 copayment (copayment not waived if admitted)	$300 copayment, no deductible
URGENT CARE CENTER	$100 copayment	50%, after deductible
AMBULANCE		
Emergency	$60 copayment	$60 copayment, no deductible
Non-emergency	$60 copayment	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY[7]		
Routine Radiology/Diagnostic	$60 copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$200 copayment	50%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[4]	$60 copayment	50%, after deductible
Cardiac rehabilitation 36 visits per year[4]	$60 copayment	50%, after deductible
Pulmonary rehabilitation 36 visits per year[4]	$60 copayment	50%, after deductible
Speech 20 visits per year[4]	$60 copayment	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year*[4]	$60 copayment	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables[8]	100%	50%, after deductible
Biotech/Specialty Injectables	$150 copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	$30 copayment	50%, after deductible
SKILLED NURSING FACILITY *120 days per year*[4]	$200 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible

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4 Combined in/out-of-network

5 Copayment waived if readmitted within 10 days of discharge.

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

7 Copayment not applicable when service performed in ER or office setting

8 Office visit subject to copayment

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

Benefit	In-network	Out-of-network[1]
HOSPICE	100%	50%, after deductible
HOME HEALTH CARE *60 visits per year*[4]	$30 copayment	50%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$60 copayment	50%, after deductible
Inpatient	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$60 copayment	50%, after deductible
Inpatient	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$60 copayment	50%, after deductible
Rehabilitation	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]
Detoxification	$400 copayment/ day; maximum 5 copayments/ admission[5]	50%, after deductible[6]

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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
- 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
- orthoptic/pleoptic
- Bariatric surgery
- private-duty nursing
- vision care (except as specified in a group contract)
- acupunture

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-ASK-BLUE (1-800-275-2583).

Certain services require preapproval/precertification by the health plan prior to being performed. To obtain a list of services that require authorization, please log on to http://www.ibx.com/preapproval or call the phone number that is listed on the back of your identification card.