Personal Choice

PHO

Independence

Drexel U.- Basic Option

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 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	$1,000
Family	$0	$600	$2,000
COINSURANCE	100%, unless otherwise noted	90%, unless otherwise noted	70%, unless otherwise noted
OUT-OF-POCKET MAXIMUM *(Deductibles, copayments, and coinsurance amounts apply to maximum)*			
Individual*	$1,000	$2,000	$3,000
Family*	$2,000	$4,000	$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

3 Combined all tiers

* Combined Tenet Preferred and Personal Choice in-network

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
MATERNITY			
First OB Visit	$10 copayment	$20 copayment, no deductible	70%, after deductible
Hospital	100%	90%, after deductible	70%, after deductible[4]
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)*	$100 copayment	$100 copayment, no deductible	$100 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	100%	$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	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	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	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible
SKILLED NURSING FACILITY	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%, no deductible	100%, no deductible	Not covered

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
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]
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.

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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
- Services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service, or supply
- Inpatient private-duty nursing
- Military or occupational injuries or illness
- Hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- Assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT
- Maintenance of chronic conditions
- Cranial prosthesis
- Charges in excess of benefit maximums or allowable charges as set forth in the 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 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).

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.