

# Personal Choice

## 20/30/70 Summary of Benefits



### PAISIG

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 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 <sup>1</sup>
<b>DEDUCTIBLE</b>		
Individual	\$0	\$500
Family	\$0	\$1,000
<b>AFTER DEDUCTIBLE, PLAN PAYS</b>	100%	70%
<b>OUT-OF-POCKET MAXIMUM</b>		
Individual	None	\$3,000
Family	None	\$6,000
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>DOCTOR'S OFFICE VISITS</b>		
Primary care services	\$20 copayment	70%, after deductible
Specialist services	\$30 copayment	70%, after deductible
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	100%	70%, after deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100%	70%, no deductible
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> 1 per calendar year for women of any age <sup>2</sup>	100%	70%, no deductible
<b>MAMMOGRAM</b>	100%	70%, no deductible

1 Out-of-network, nonparticipating 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.

2 Combined in/out-of-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.

[www.ibx.com](http://www.ibx.com)

Benefit	In-network	Out-of-network <sup>1</sup>
<b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b> 6 visits per calendar year <sup>2</sup>	100%	70%, after deductible
<b>MATERNITY</b>		
First OB visit	\$20 copayment	70%, after deductible
Hospital	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>
<b>INPATIENT HOSPITAL SERVICES</b>	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70 <sup>4</sup>
<b>OUTPATIENT SURGERY</b>	\$150 copayment	70%, after deductible
<b>EMERGENCY ROOM</b>	\$150 copayment (copayment waived if admitted)	\$150 copayment, no deductible (copayment waived if admitted)
<b>AMBULANCE</b>		
Emergency	100%	100%, no deductible
Non-emergency	100%	70%, after deductible
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%	70%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY</b> Copayment not applicable when service performed in ER or office setting	\$30 copayment	70%, after deductible
<b>THERAPY SERVICES</b>		
Physical, speech and occupational 60 visits per calendar year <sup>2</sup>	\$20 copayment [visits 1-30] \$30 copayment [visits 31-60]	70%, after deductible
Cardiac rehabilitation 36 visits per calendar year <sup>2</sup>	\$20 copayment	70%, after deductible
Pulmonary rehabilitation 12 visits per calendar year <sup>2</sup>	\$20 copayment	70%, after deductible
Respiratory therapy	\$20 copayment	70%, after deductible
<b>RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per calendar year)<sup>2</sup></b> Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum <sup>2</sup>	\$30 copayment	70%, after deductible
<b>CHEMO/RADIATION/DIALYSIS</b>	100%	70%, after deductible
<b>OUTPATIENT PRIVATE DUTY NURSING</b> 360 hours per calendar year <sup>2</sup>	100%	70%, after deductible
<b>SKILLED NURSING FACILITY</b> 120 days per calendar year <sup>2</sup>	100%	70%, after deductible
<b>HOSPICE AND HOME HEALTH CARE</b>	100%	70%, after deductible
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETICS</b> Copayment per rental period or item purchased	\$30 copayment	70%, after deductible
<b>OUTPATIENT DIABETIC EDUCATION</b>	100%	Not covered

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2 Combined in/out-of-network.

3 Copayment waived if readmitted within 90 days of discharge (10 days on or after 1/1/2011).

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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Benefit	In-network	Out-of-network <sup>1</sup>
<b>MENTAL HEALTH CARE</b>		
Outpatient	\$30 copayment	70%, after deductible
Inpatient	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>
<b>SERIOUS MENTAL ILLNESS CARE</b>		
Outpatient	\$30 copayment	70%, after deductible
Inpatient	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>
<b>SUBSTANCE ABUSE TREATMENT</b>		
Outpatient/Partial facility visits	\$30 copayment	70%, after deductible
Rehabilitation	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>
Detoxification	\$150 per day (maximum of 5 copayments per admission) <sup>3</sup>	70%, after deductible <sup>4</sup>

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## What is not covered?

- services not medically necessary
- services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service, or supply
- cosmetic services/supplies
- routine foot care
- supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- 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
- assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT
- charges in excess of benefit maximums or allowable charges as set forth in the group contract
- services or supplies that are experimental or investigative except routine costs associated with clinical trials
- inpatient private-duty nursing
- alternative therapies/complementary medicine
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- contraceptives
- immunizations required for employment or travel
- 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. This managed care plan may not cover all of your health care expenses. Read your benefits booklet 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).

## Services that require pre-authorization

Service	In-network (Personal Choice® network provider or BlueCard® PPO provider)	Out-of-network
<b>ALL NON-EMERGENCY INPATIENT ADMISSIONS</b> (Except maternity admissions)	Required	Required
<b>OUTPATIENT SURGICAL PROCEDURES</b>		
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
Varicose vein procedures	Required	Required
Obesity surgery	Required	Required
Orthognathic surgery procedures	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
<b>TRANSPLANTS</b>	Required	Required
<b>OPERATIVE AND DIAGNOSTIC ENDOSCOPIES</b>	Not Required	Required
<b>MRI/MRA</b>	Required	Required
<b>CT/CTA SCAN</b>	Required	Required
<b>PET SCAN</b>	Required	Required
<b>NUCLEAR CARDIAC STUDIES</b>	Required	Required
<b>OUTPATIENT THERAPIES:</b> Speech, cardiac, pulmonary, respiratory	Required	Required
<b>OUTPATIENT PRIVATE DUTY NURSING</b>	Required	Required
<b>OTHER FACILITY SERVICES:</b> Skilled nursing, Inpatient hospice, Home health, Birth center	Required	Required
<b>MENTAL HEALTH, SUBSTANCE ABUSE, AND SERIOUS MENTAL ILLNESS TREATMENT</b>		
Inpatient	Required	Required
Partial hospitalization programs/intensive outpatient programs	Required	Not Required
<b>DAY REHABILITATION PROGRAMS</b>	Required	Required
<b>DENTAL SERVICES AS A RESULT OF ACCIDENTAL INJURY</b>	Required	Required
<b>NON-EMERGENCY AMBULANCE</b>	Required	Required
<b>DURABLE MEDICAL EQUIPMENT</b> Purchase items (including repairs and replacements) over \$500, and ALL rentals (except oxygen, diabetic supplies, and unit dose medication for nebulizer)	Required	Required
<b>PROSTHETICS AND ORTHOTICS</b> Purchase items (including repairs and replacements) over \$500 (excluding ostomy supplies)	Required	Required
<b>INFUSION THERAPY IN A HOME SETTING</b>	Required	Required
<b>INFUSION THERAPY DRUGS</b> 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. Additionally, a 50% reduction in benefits may apply for failure to preauthorize speech therapy.

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.