

# Personal Choice

25/35/50



## School District of Phila.

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<sup>®</sup> 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>BENEFIT PERIOD</b>	Calendar Year <sup>2</sup>	Calendar Year <sup>2</sup>
<b>DEDUCTIBLE</b>		
Individual	\$0	\$2,000
Family	\$0	\$6,000
<b>AFTER DEDUCTIBLE, PLAN PAYS</b>	100% Unless otherwise specified	50%
<b>OUT-OF-POCKET MAXIMUM<sup>**</sup></b>		
Individual	\$1,000	\$3,000
Family	\$2,000	\$6,000
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>DOCTOR'S OFFICE VISITS</b>		
Primary care services	\$25 copayment	50%, after deductible
Specialist services	\$35 copayment	50%, after deductible
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	100%	50%, no deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100% (office visit copayment does not apply)	50%, no deductible
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> <i>1 per year for women of any age<sup>3</sup></i>	100%	50%, no deductible

<sup>1</sup> Non-Preferred Providers may bill you the 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, payment is 50% of the actual charge of the provider. For services rendered by hospitals and other facility providers in the local service area, the allowance may not refer to the actual amount paid by Personal Choice to 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.

<sup>2</sup> Combined in/out-of-network

<sup>\*</sup> A calendar year benefit period begins on January 1 and ends on December 31. The deductible and out-of-pocket maximum amount start at \$0 at the beginning of each calendar year on January 1.

<sup>\*\*</sup> In-network out-of-pocket maximum includes copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

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>MAMMOGRAM</b>	100%	50%, no deductible
<b>ASSISTED REPRODUCTIVE TECHNOLOGIES</b>	100%	50%, no deductible
<b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b> <i>6 visits per year<sup>f</sup></i>	100%	50%, after deductible
<b>ALLERGY INJECTIONS</b> <i>(Office visit copayment waived if no office visit is charged)</i>	100%	50%, after deductible
<b>MATERNITY</b>		
First OB visit	\$20 copayment	50%, after deductible
Hospital	100%	50%, after deductible <sup>3</sup>
<b>INPATIENT HOSPITAL SERVICES</b>		
Facility	100%	50%, after deductible <sup>3</sup>
Physician/Surgeon	100%	50%, after deductible
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70 <sup>3</sup>
<b>OUTPATIENT SURGERY</b>		
Facility	100%	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
<b>EMERGENCY ROOM</b>	\$100 copayment (copayment waived if admitted)	\$100 copayment, no deductible (copayment waived if admitted)
<b>URGENT CARE CENTER</b>	\$35 copayment	50%, after deductible
<b>AMBULANCE</b>		
Emergency	100%	100%, no deductible
Non-emergency	100%	50%, after deductible
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%	50%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY</b>		
Routine Radiology/Diagnostic	\$30 copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%	50%, after deductible
<b>CT/CTA SCAN, MRI/MRA, PET SCAN</b>	100%	50%, after deductible
<b>THERAPY SERVICES</b>		
Physical, speech and occupational 60 visits per year for PT/ST/OT combined <sup>e</sup>	\$20 copayment [visits 1-30] \$30 copayment [visits 31-60]	50%, after deductible
Cardiac rehabilitation 36 visits per year <sup>e</sup>	\$20 copayment	50%, after deductible
Pulmonary rehabilitation 12 visits per year <sup>e</sup>	\$20 copayment	50%, after deductible
Respiratory therapy	\$20 copayment	50%, after deductible
<b>RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per year)<sup>2</sup></b> <i>Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum<sup>e</sup></i>	\$30 copayment	50%, after deductible
<b>CHEMO/RADIATION/DIALYSIS</b>	100%	50%, after deductible
<b>SELF INJECTABLE DRUGS</b>	100%	Not covered
<b>OUTPATIENT PRIVATE DUTY NURSING</b> <i>360 hours per year<sup>f</sup></i>	100%	50%, after deductible
<b>SKILLED NURSING FACILITY</b> <i>120 days per year<sup>f</sup></i>	100%	50%, after deductible

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2 Combined in/out-of-network

3 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.

Benefit	In-network	Out-of-network <sup>1</sup>
<b>HOSPICE AND HOME HEALTH CARE</b>	100%	50%, after deductible
<b>DURABLE MEDICAL EQUIPMENT AND PROSTHETICS</b> <i>Copayment per rental period or item purchased</i>	\$30 copayment	50%, after deductible
<b>OUTPATIENT DIABETIC EDUCATION</b>	100%	Not covered
<b>MENTAL HEALTH CARE</b>		
Outpatient	\$30 copayment	50%, after deductible
Inpatient	100%	50%, after deductible <sup>3</sup>
<b>SERIOUS MENTAL ILLNESS CARE</b>		
Outpatient	\$30 copayment	50%, after deductible
Inpatient	100%	50%, after deductible <sup>3</sup>
<b>SUBSTANCE ABUSE TREATMENT</b>		
Outpatient/Partial facility visits	\$30 copayment	50%, after deductible
Rehabilitation	100%	50%, after deductible <sup>3</sup>
Detoxification	100%	50%, after deductible <sup>3</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
- 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
- immunizations required for employment or travel

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).

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.