# Personal Choice

Summary of Benefits

## *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® 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** | Calendar Year* | Calendar Year* |
| **DEDUCTIBLE** | | |
| Individual | $0 | $500 |
| Family | $0 | $1,000 |
| **AFTER DEDUCTIBLE, PLAN PAYS** | 100%<br>Unless otherwise specified | 70% |
| **OUT-OF-POCKET MAXIMUM**** | | |
| Individual | $1,000 | $3,000 |
| Family | $2,000 | $6,000 |
| **LIFETIME MAXIMUM** | Unlimited | Unlimited |
| **DOCTOR'S OFFICE VISITS** | | |
| Primary care services | $20 copayment | 70%, after deductible |
| Specialist services | $30 copayment | 70%, after deductible |
| **PREVENTIVE CARE FOR ADULTS AND CHILDREN** | 100% | 70%, no deductible |
| **PEDIATRIC IMMUNIZATIONS** | 100% (office visit copayment does not apply) | 70%, no deductible |
| **ROUTINE GYNECOLOGICAL EXAM/PAP**<br>1 per year for women of any age[2] | 100% | 70%, no deductible |

1 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.

2 Combined in/out-of-network

* 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.

** 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**

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| Benefit | In-network | Out-of-network[1] |
| --- | --- | --- |
| **MAMMOGRAM** | 100% | 70%, no deductible |
| **ASSISTED REPRODUCTIVE TECHNOLOGIES** | 100% | 70%, no deductible |
| **NUTRITION COUNSELING FOR WEIGHT MANAGEMENT**<br>6 visits per year[2] | 100% | 70%, after deductible |
| **ALLERGY INJECTIONS**<br>(Office visit copayment waived if no office visit is charged) | 100% | 70%, after deductible |
| **MATERNITY** | | |
| First OB visit | $20 copayment | 70%, after deductible |
| Hospital | 100% | 70%, after deductible[3] |
| **INPATIENT HOSPITAL SERVICES** | | |
| Facility | 100% | 70%, after deductible[3] |
| Physician/Surgeon | 100% | 70%, after deductible |
| **INPATIENT HOSPITAL DAYS** | Unlimited | 70[3] |
| **OUTPATIENT SURGERY** | | |
| Facility | 100% | 70%, after deductible |
| Physician/Surgeon | 100% | 70%, after deductible |
| **EMERGENCY ROOM** | $40 copayment (copayment waived if admitted) | $40 copayment, no deductible (copayment waived if admitted) |
| **URGENT CARE CENTER** | $30 copayment | 70%, after deductible |
| **AMBULANCE** | | |
| Emergency | 100% | 100%, no deductible |
| Non-emergency | 100% | 70%, after deductible |
| **OUTPATIENT LABORATORY/PATHOLOGY** | 100% | 70%, after deductible |
| **OUTPATIENT X-RAY/RADIOLOGY** | | |
| Routine Radiology/Diagnostic | $30 copayment | 70%, after deductible |
| MRI/MRA, CT/CTA Scan, PET Scan | 100% | 70%, after deductible |
| **CT/CTA SCAN, MRI/MRA, PET SCAN** | 100% | 70%, after deductible |
| **THERAPY SERVICES** | | |
| Physical, speech and occupational<br>60 visits per year for PT/ST/OT combined[2] | $20 copayment [visits 1-30] $30 copayment [visits 31-60] | 70%, after deductible |
| Cardiac rehabilitation<br>36 visits per year[2] | $20 copayment | 70%, after deductible |
| Pulmonary rehabilitation<br>12 visits per year[2] | $20 copayment | 70%, after deductible |
| Respiratory therapy | $20 copayment | 70%, after deductible |
| **RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per year)**[2]<br>Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum[2] | $30 copayment | 70%, after deductible |
| **CHEMO/RADIATION/DIALYSIS** | 100% | 70%, after deductible |
| **SELF INJECTABLE DRUGS** | 100% | Not covered |
| **OUTPATIENT PRIVATE DUTY NURSING**<br>360 hours per year[2] | 100% | 70%, after deductible |
| **SKILLED NURSING FACILITY**<br>120 days per year[2] | 100% | 70%, 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[1] |
|---|---|---|
| **HOSPICE AND HOME HEALTH CARE** | 100% | 70%, after deductible |
| **DURABLE MEDICAL EQUIPMENT AND PROSTHETICS**<br>Copayment per rental period or item purchased | $30 copayment | 70%, after deductible |
| **OUTPATIENT DIABETIC EDUCATION** | 100% | Not covered |
| **MENTAL HEALTH CARE** | | |
| Outpatient | $30 copayment | 70%, after deductible |
| Inpatient | 100% | 70%, after deductible[3] |
| **SERIOUS MENTAL ILLNESS CARE** | | |
| Outpatient | $30 copayment | 70%, after deductible |
| Inpatient | 100% | 70%, after deductible[3] |
| **SUBSTANCE ABUSE TREATMENT** | | |
| Outpatient/Partial facility visits | $30 copayment | 70%, after deductible |
| Rehabilitation | 100% | 70%, after deductible[3] |
| Detoxification | 100% | 70%, after deductible[3] |

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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).

## 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 (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 (excluding 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. 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.