Personal Choice

10/20/70 Summary of Benefits

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 referrals

Benefit	In-network	Out-of-network[1]
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE		
Individual	$0	$300
Family	$0	$600
AFTER DEDUCTIBLE, PLAN PAYS	100%	70%
OUT-OF-POCKET MAXIMUM**		
Individual	$1,500	$2,000
Family	$3,000	$4,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$10 copayment	70%, after deductible
Specialist services	$20 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

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, the 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 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.

* 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 Amerihealth to comply with applicable federal/state laws and regulations.

Independence

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Benefit	In-network	Out-of-network[1]
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age[3]	100%	70%, no deductible
MAMMOGRAM	100%	70%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per year[3]	100%	70%, after deductible
ALLERGY INJECTIONS (Office visit copayment waived if no office visit is charged)	100%	70%, after deductible
MATERNITY		
First OB visit	$10 copayment	70%, after deductible
Hospital	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible
INPATIENT HOSPITAL SERVICES		
Facility	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70
OUTPATIENT SURGERY		
Facility	$75 copayment	70%, after deductible
Physician/Surgeon	$75 copayment	70%, after deductible
EMERGENCY ROOM	$40 copayment (copayment waived if admitted)	$40 copayment, no deductible (copayment waived if admitted)
AMBULANCE		
Emergency	100%	100%
Non-emergency	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY Copayment not applicable when service performed in ER or office setting	$20 copayment	70%, after deductible
THERAPY SERVICES		
Physical, speech and occupational 60 visits per year for PT/ST/OT combined[3]	$15 copayment [visits 1-30] $25 copayment [visits 31-60]	70%, after deductible
Cardiac rehabilitation 36 visits per year[3]	$15 copayment	70%, after deductible
Pulmonary rehabilitation 12 visits per year[3]	$15 copayment	70%, after deductible
Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum[3]	$15 copayment	70%, after deductible

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3 Combined in/out-of-network

4 Copayment waived if readmitted within 10 days of discharge

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Benefit	In-network	Out-of-network[1]
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per year)[3]	$20 copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per year[3]	100%	70%, after deductible
SKILLED NURSING FACILITY 120 days per year[3]	100%	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS Copayment per rental period or item purchased	$20 copayment	70%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
MENTAL HEALTH CARE		
Outpatient 30 visits per year[3]	$20 copayment	50%, after deductible, up to 20 visits per year
Inpatient 30 days per year[3]	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible, up to 20 days per year
SERIOUS MENTAL ILLNESS CARE		
Outpatient 60 days per year[3]	$20 copayment	50%, after deductible
Inpatient 30 days per year[3]	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits 60 visits per year[3] ,120 visits per lifetime maximum[3]	100%	70%, after deductible
Rehabilitation 30 days per year[3] ,90 days per lifetime maximum[3]	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible
Detoxification 7 days per admission[3] ,4 admissions per lifetime maximum[3]	$75 per day (maximum of 5 copayments per admission)[4]	70%, after deductible

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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
- 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

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
Anthroscopic 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	Not 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
OUTPATIENT THERAPIES: Speech	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.