

Personal Choice

PHO



DUCOM - 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 ¹
DEDUCTIBLE			
Individual	\$0	\$300	\$750
Family	\$0	\$600	\$1,500
COINSURANCE	100%, unless noted	90%, unless noted	70%, unless noted
OUT-OF-POCKET MAXIMUM (Deductibles, copayments, and coinsurance amounts apply to maximum)			
Individual ²	\$1,000	\$1,000	\$3,000
Family ²	\$2,000	\$2,000	\$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

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. 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.

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 underwritten or administered by QCC Insurance Company, a subsidiary of Independence Blue Cross-independent licensees of the Blue Cross and Blue Shield Association.

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Benefits	In-Network Tenet Preferred	Personal Choice Network	Out-of-Network Out-of-Network ¹
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
MATERNITY			
First OB Visit	\$10 copayment	\$20 copayment, no deductible	70%, after deductible
Hospital	100%	90%, after deductible	70%, after deductible ⁵
INPATIENT HOSPITAL SERVICES			
Facility	100%	90%, after deductible	70%, after deductible ⁵
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)	\$75 copayment	\$75 copayment, no deductible	\$75 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 60 visits maximum per calendar year combined for PT, OT and Speech ³	Provider is only available in Personal Choice Network	\$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 60 visits maximum per calendar year combined for PT, OT and Speech ³	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 30 visits per calendar year ³	Provider is only available in Personal Choice Network	\$30 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 360 hours maximum per calendar year ³	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible
SKILLED NURSING FACILITY 120 days maximum per calendar year ³	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible ⁵
HOME HEALTH CARE	100%	90%, after deductible	70%, after deductible
HOSPICE	100%	90%, after deductible	70%, after deductible

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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.

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Benefits	In-Network Tenet Preferred	Personal Choice Network	Out-of-Network Out-of-Network ¹
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
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 ⁵
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 ⁵
ALCOHOL AND DRUG ABUSE TREATMENT			
Detoxification	Provider is only available in Personal Choice Network	90%, after deductible	70%, after deductible ⁵
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 ⁵

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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

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).

Services That Require Precertification

INPATIENT SERVICES

Surgical and Nonsurgical Inpatient Admissions
 Acute Rehabilitation
 Skilled Nursing Facility
 Inpatient Hospice

OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

MRI/MRA
 CT/CTA Scan
 PET Scan
 Nuclear Cardiac Studies
 Hyperbaric Oxygen
 Hysterectomy
 Cataract Surgery
 Cochlear implant surgery
 Nasal Surgery for Submucous Resection and Septoplasty
 Transplants (except cornea)
 Pain management procedures (including epidural injections, transforaminal epidural injections, paravertebral facet joint injections)
 Obesity Surgery
 Day Rehabilitation Programs
 Dental Services as a Result of Accidental Injury
 Uvulopalatopharyngoplasty (including laser-assisted)

ALL HOME CARE SERVICES (including infusion therapy in the home)

INFUSION THERAPY DRUGS

Administered in an Outpatient Facility or in a Professional Provider's Office (see list included in your open enrollment packet)

MATERNITY ADMISSION AND BIRTHING CENTER (prenotification requested only)

ELECTIVE (non-emergency) AMBULANCE TRANSPORT

OUTPATIENT PRIVATE DUTY NURSING

PROSTHETICS AND ORTHOTICS

Purchase items (including repairs and replacements) over \$500 (excluding ostomy supplies)

DURABLE MEDICAL EQUIPMENT

Purchase items (including repairs and replacements) over \$500, and ALL rentals (except oxygen, diabetic supplies and unit dose medication for nebulizer)

RECONSTRUCTIVE PROCEDURES & POTENTIALLY COSMETIC PROCEDURES

Blepharoplasty/ptosis repair
 Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants
 Canthopexy/canthoplasty
 Cervicoplasty
 Chemical Peels
 Dermabrasion
 Excision of excessive skin and/or subcutaneous tissue
 Genetically and bio-engineered skin substitutes for wound care
 Hair transplant
 Injectable dermal fillers
 Keloid Removal
 Labiaplasty
 Lipectomy, liposuction, or any other excess fat removal procedure
 Orthognathic surgery procedures, including but not limited to, bone graft, genioplasty, osteoplasty, mentoplasty, osteotomies
 Otoplasty
 Rhinoplasty
 Rhytidectomy
 Scar Revision
 Skin closures, including skin grafts, skin flaps, tissue grafts
 Sex reassignment surgery
 Surgical treatment of gynecomastia
 Surgery for varicose veins, including perforators and sclerotherapy

MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

Mental Health & Serious Mental Illness Treatment
(Inpatient/partial hospitalization programs/intensive outpatient programs)
 Substance Abuse Treatment
(Inpatient/Outpatient/Partial Hospitalization)

BIOTECHNOLOGY/SPECIALTY INJECTABLE DRUGS

(See list included in your open enrollment packet)

Personal Choice® network providers will obtain precertification for you if it is required. You are not required to obtain precertification when treated in a Personal Choice network hospital or facility or, by a Personal Choice network physician. Members are not responsible for financial penalties because a Personal Choice network provider does not obtain precertification.

If the provider is a BlueCard® PPO provider of another Blue Plan or an out-of-network provider, you must obtain precertification if required. You may be subject to a 20% reduction in benefits if precertification is not obtained.

In addition to the precertification requirements listed above, you should contact Independence Blue Cross and provide prenotification for certain categories of treatment so you will know prior to receiving treatment whether it is a covered service. This applies to network providers and members who elect to receive treatment provided by BlueCard providers, or out-of-network providers. The categories of treatment (in any setting) include:

- Any surgical procedure that may be considered potentially cosmetic; and
- Any procedure, treatment, drug, or device that represents new or emerging technology; and
- Services that might be considered experimental/investigative.

Your provider should be able to assist you in determining whether a proposed treatment falls into one of these three categories. You are encouraged to have your provider place the call for you.

Precertification 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 precertification 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.