Personal Choice

Summary of Benefits

Drexel College of Medicine - 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 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

Benefit	In-network	Out-of-network[1]
DEDUCTIBLE		
Individual	$300	$750
Family	$600	$1,500
AFTER DEDUCTIBLE, PLAN PAYS	90%	70%
OUT-OF-POCKET MAXIMUM		
Individual	$1,000	$3,000
Family	$2,000	$6,000
LIFETIME MAXIMUM	Unlimited	$500,000
DOCTOR'S OFFICE VISITS		
Primary care services	$20 copayment, no deductible	70%, after deductible
Specialist services	$30 copayment, no deductible	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	$20 copayment, no deductible	70%, after deductible
PEDIATRIC IMMUNIZATIONS	100%[2] ,no deductible	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age[3]	100%, no deductible	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 Office visit subject to copayment

3 Combined in/out-of-network

Independence Blue Cross

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Benefit	In-network	Out-of-network[1]
MAMMOGRAM	100%, no deductible	70%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year[3]	100%, no deductible	70%, after deductible
MATERNITY		
First OB visit	$20 copayment, no deductible	70%, after deductible
Hospital	90%, after deductible	70%, after deductible[4]
INPATIENT HOSPITAL SERVICES	90%, after deductible	70%, after deductible[4]
INPATIENT HOSPITAL DAYS	Unlimited	70[4]
OUTPATIENT SURGERY	90%, after deductible	70%, after deductible
EMERGENCY ROOM	$40 copayment, no deductible (copayment waived if admitted)	$40 copayment, no deductible (copayment waived if admitted)
OUTPATIENT LABORATORY/PATHOLOGY	100%, no deductible	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY	90%, after deductible	70%, after deductible
THERAPY SERVICES		
Physical, speech and occupational	$30 copayment, no deductible	70%, after deductible
Cardiac rehabilitation 36 visits per calendar year[3]	$30 copayment, no deductible	70%, after deductible
Pulmonary rehabilitation 12 visits per calendar year[3]	$30 copayment, no deductible	70%, after deductible
Respiratory therapy	$30 copayment, no deductible	70%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum[3]	$30 copayment, no deductible	70%, after deductible
CHEMO/RADIATION/DIALYSIS	90%, after deductible	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	90%, after deductible	70%, after deductible
SKILLED NURSING FACILITY	90%, after deductible	70%, after deductible
HOSPICE AND HOME HEALTH CARE	90%, after deductible	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS	90%, after deductible	70%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%, no deductible	Not covered
MENTAL HEALTH CARE		
Outpatient	$30 copayment, no deductible	70%, after deductible
Inpatient	90%, after deductible	70%, after deductible[4]

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3 Combined in/out-of-network

4 Inpatient hospital day limit combined for all out-of-network inpatient medical, maternity, mental health, serious mental illness and substance abuse services

Benefit	In-network	Out-of-network[1]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 copayment, no deductible	70%, after deductible
Inpatient	90%, after deductible	70%, after deductible[4]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$30 copayment, no deductible	70%, after deductible
Rehabilitation	90%, after deductible	70%, after deductible[4]
Detoxification	90%, after deductible	70%, after deductible[4]

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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
- maintenance of chronic conditions
- contraceptives
- immunizations required for employment or travel
- self-injectable drugs (effective 1/1/2010)

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
OUTPATIENT SURGICAL PROCEDURES		
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
Ligation and stripping of varicose veins	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
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, cardiac, pulmonary, respiratory	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	Not 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.

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.