Personal Choice

C3-F1-01

Personal Choice® pur 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]
BENEFIT PERIOD	Calendar Year*	Calendar Year*
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,500
OUT-OF-POCKET MAXIMUM[5]		
Individual	$1,500	$7,600
Family	$3,000	$22,800
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$20 copayment	70%, after deductible
Specialist services	$40 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 *1 per year for women of any age*[3]	100%	70%, no deductible
MAMMOGRAM	100%	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, 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, the 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.

3 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.

5 The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible. The 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.

Independence

06/14 - PA - 51+ PC C3-F1-01 - OOPM 2015
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Benefit	In-network	Out-of-network[1]
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[3]	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
MATERNITY		
First OB visit	$20 copayment	70%, after deductible
Hospital	100%	70%, after deductible[4]
INPATIENT HOSPITAL SERVICES		
Facility	100%	70%, after deductible[4]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[4]
OUTPATIENT SURGERY		
Facility	100%	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$100 copayment (copayment not waived if admitted)	$100 copayment (copayment not waived if admitted); no deductible
URGENT CARE CENTER	$70 copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, no deductible
Non-emergency	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY *(Copayment not applicable when service performed in ER or office setting)*		
Routine Radiology/Diagnostic	$40 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$80 copayment	70%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[3]	$40 copayment	70%, after deductible
Cardiac rehabilitation 36 visits per year[3]	$40 copayment	70%, after deductible
Pulmonary rehabilitation 36 visits per year[3]	$40 copayment	70%, after deductible
Speech 20 visits per year[3]	$40 copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum[3]	$40 copayment	70%, after deductible
SPINAL MANIPULATIONS *20 visits per year*[3]	$40 copayment	70%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%	70%, after deductible
Biotech/Specialty Injectables	$100 copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible

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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.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	In-network	Out-of-network[1]
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*[3]	90%	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	70%	50%, after deductible
PROSTHETICS	70%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$40 copayment	70%, after deductible
Inpatient	100%	70%, after deductible[4]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$40 copayment	70%, after deductible
Inpatient	100%	70%, after deductible[4]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$40 copayment	70%, after deductible
Rehabilitation	100%	70%, after deductible[4]
Detoxification	100%	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.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

What is not covered?

- services not medically necessary
- services or supplies that are experimental or investigative except routine costs associated with clinical trials
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- 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 an 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
- cranial prostheses including wigs intended to replace hair
- routine physical exams for nonpreventive purposes such as insurance or employment applications, college, or premarital examinations
- immunizations for travel or employment
- services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- cosmetic services/supplies
- self-injectable drugs
- vision care (except as specified in a group contract)

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-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.

Personal Choice

C4-F3-02

Independence

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- 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	$1,500
Family	$0	$4,500
OUT-OF-POCKET MAXIMUM**		
Individual	$3,500	$10,000
Family	$7,000	$30,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$30 copayment	50%, after deductible
Specialist services	$50 copayment	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	50%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[3]	100%	50%, no deductible
MAMMOGRAM	100%	50%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[3]	100%	50%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	50%, after deductible

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3 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.

** The in-network out-of-pocket maximum includes the copayments, coinsurance and deductible. The 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.

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09/16 - PA - 51+ PC C4-F4-02 - OOPM 2017
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Benefit	In-network	Out-of-network[1]
MATERNITY		
First OB visit	$30 copayment	50%, after deductible
Hospital	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]
INPATIENT HOSPITAL SERVICES		
Facility	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]
Physician/Surgeon	100%	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[5]
OUTPATIENT SURGERY		
Facility	$75 copayment	50%, after deductible
Physician/Surgeon	100%	50%, after deductible
EMERGENCY ROOM	$100 copayment (copayment not waived if admitted)	$100 copayment (copayment not waived if admitted); no deductible
URGENT CARE CENTER	$70 copayment	50%, after deductible
AMBULANCE		
Emergency	100%	100%, no deductible
Non-emergency	100%	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY *(Copayment not applicable when service performed in ER or office setting)*		
Routine Radiology/Diagnostic	$50 copayment	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$100 copayment	50%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[3]	$50 copayment	50%, after deductible
Cardiac rehabilitation 36 visits per year[3]	$50 copayment	50%, after deductible
Pulmonary rehabilitation 36 visits per year[3]	$50 copayment	50%, after deductible
Speech 20 visits per year[3]	$50 copayment	50%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[3]	$50 copayment	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year[3]*	$50 copayment	50%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%[2]	50%, after deductible
Biotech/Specialty Injectables	$125 copayment	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year[3]*	85%	50%, after deductible
SKILLED NURSING FACILITY *120 days per year[3]*	$75/day; maximum of 5 copayments/admission[4]	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	50%, after deductible

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2 Office visit subject to copayment

3 Combined in/out-of-network

4 Copayment waived if readmitted within 10 days of discharge

5 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]
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$50 copayment	50%, after deductible
Inpatient	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$50 copayment	50%, after deductible
Inpatient	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$50 copayment	50%, after deductible
Rehabilitation	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]
Detoxification	$150/day; maximum of 5 copayments/admission[4]	50%, after deductible[5]

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5 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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What is not covered?

- services not medically necessary
- services or supplies which are experimental or investigative except routine costs associated with clinical trials
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- assisted fertilization techniques such as in-vitro fertilization, GIFT and ZIFT
- reversal of voluntary sterilization
- expenses related to organ donation for non-member recipients
- alternative Therapies/complementary medicine
- dental care, including dental implants, and non-surgical 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 an 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
- cranial prostheses including wigs intended to replace hair
- routine physical exams for non-preventive purposes such as insurance or employment applications, college, or premarital examinations
- immunizations for travel or employment
- services or supplies payable under Workers' Compensation, Motor Vehicle Insurance, or other legislation of similar purpose
- cosmetic services/supplies
- self-injectable drugs
- vision care (except as specified in a group contract)

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Personal Choice

HDHP HD1-HC1

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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	Contract Year*	Contract Year*
DEDUCTIBLE**		
Single	$1,500	$5,000
Family	$3,000	$10,000
OUT-OF-POCKET MAXIMUM[2]		
Single	$5,600	$10,000
Family	$11,200	$20,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	100%, after deductible	50%, after deductible
Specialist services	100%, after deductible	50%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, no deductible	50%, no deductible
PEDIATRIC IMMUNIZATIONS	100%, no deductible	50%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[3]	100%, no deductible	50%, no deductible
MAMMOGRAM	100%, no deductible	50%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[3]	100%, no deductible	50%, after deductible

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2 In-network out-of-pocket maximum includes copayments, coinsurance and deductible. Out-of-network out-of-pocket maximum includes coinsurance only.

3 Combined in/out-of-network

* A contract year benefit period is a consecutive 12-month period that begins on your employer's effective date. The deductible and out-of-pocket maximum amount start at $0 at the beginning of each contract year.

** Single deductible and out-of-pocket maximum amount shown applies for self-only contracts. For family contracts (an individual enrolled with one or more dependents), in-network benefits are subject to the family deductible amount which can be met by any combination of family members. However, no family member will be subject to more than the single out-of-pocket maximum shown above. Benefits are covered at the indicated percentage for that service until the single maximum out-of-pocket or the family maximum out-of-pocket is met. The in-network family out-of-pocket amount can be met by any combination of family members.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Independence

Benefit	In-network	Out-of-network[1]
OUTPATIENT LABORATORY/PATHOLOGY	100%, after deductible	50%, after deductible
MATERNITY		
First OB visit	100%, after deductible	50%, after deductible
Hospital	100%, after deductible	50%, after deductible[4]
INPATIENT HOSPITAL SERVICES		
Facility	100%, after deductible	50%, after deductible[4]
Physician/Surgeon	100%, after deductible	50%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[4]
OUTPATIENT SURGERY		
Facility	100%, after deductible	50%, after deductible
Physician/Surgeon	100%, after deductible	50%, after deductible
EMERGENCY ROOM	100%, after deductible	100%, after in-network deductible
URGENT CARE CENTER	100%, after deductible	50%, after deductible
AMBULANCE		
Emergency	100%, after deductible	100%, after in-network deductible
Non-emergency	100%, after deductible	50%, after deductible
OUTPATIENT X-RAY/RADIOLOGY		
Routine Radiology/Diagnostic	100%, after deductible	50%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	100%, after deductible	50%, after deductible
THERAPY SERVICES		
Physical and occupational 30 total visits per year for PT/OT combined[3]	100%, after deductible	50%, after deductible
Cardiac rehabilitation 36 visits per year [3]	100%, after deductible	50%, after deductible
Pulmonary rehabilitation 36 visits per year [3]	100%, after deductible	50%, after deductible
Speech 20 visits per year [3]	100%, after deductible	50%, after deductible
Orthoptic/pleoptic 8 sessions lifetime maximum[3]	100%, after deductible	50%, after deductible
SPINAL MANIPULATIONS *20 visits per year* [3]	100%, after deductible	50%, after deductible
ALLERGY INJECTIONS	100%, after deductible	50%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%, after deductible	50%, after deductible
Biotech/Specialty Injectables	100%, after deductible	50%, after deductible
CHEMO/RADIATION/DIALYSIS	100%, after deductible	50%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year* [3]	100%, after deductible	50%, after deductible
SKILLED NURSING FACILITY *120 days per year* [3]	100%, after deductible	50%, after deductible
HOSPICE AND HOME HEALTH CARE	100%, after deductible	50%, after deductible
DURABLE MEDICAL EQUIPMENT	100%, after deductible	50%, after deductible
PROSTHETICS	100%, after deductible	50%, after deductible

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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.

The benefits may be changed by IBC to comply with applicable federal/state laws and regulations.

Benefit	In-network	Out-of-network[1]
MENTAL HEALTH CARE		
Outpatient	100%, after deductible	50%, after deductible
Inpatient	100%, after deductible	50%, after deductible[4]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	100%, after deductible	50%, after deductible
Inpatient	100%, after deductible	50%, after deductible[4]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	100%, after deductible	50%, after deductible
Rehabilitation	100%, after deductible	50%, after deductible[4]
Detoxification	100%, after deductible	50%, after deductible[4]

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- assisted fertilization techniques such as in-vitro fertilization, GIFT, and ZIFT
- 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
- cranial prostheses including wigs intended to replace hair
- routine physical exams for nonpreventive 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
- self-injectable drugs
- vision care (except as specified in a group contract)

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-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.