

Please be aware, benefit explanations are updated each year and when the carrier issues a policy change in writing.



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# Personal Choice

## D1-N2 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 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

| Benefit  | In-Network                        | Out-of-Network <sup>1</sup> |
|--|-----------------------------------|-----------------------------|
| <b>DEDUCTIBLE</b>  |                                   |                             |
| Individual   | \$500                             | \$5,000                     |
| Family   | \$1,500                           | \$15,000                    |
| <b>AFTER DEDUCTIBLE, PLAN PAYS</b>   |                                   |                             |
|  | 70%                               | 50%                         |
| <b>OUT-OF-POCKET MAXIMUM</b>   |                                   |                             |
| Individual   | \$5,000                           | \$15,000                    |
| Family   | \$15,000                          | \$45,000                    |
| <b>LIFETIME MAXIMUM</b>  |                                   |                             |
|  | Unlimited                         | \$500,000                   |
| <b>DOCTOR'S OFFICE VISITS</b>  |                                   |                             |
| Primary Care Services  | \$20 Copayment, NO deductible     | 50%, after deductible       |
| Specialist Services  | \$40 Copayment, NO deductible     | 50%, after deductible       |
| <b>PEDIATRIC IMMUNIZATIONS</b>   |                                   |                             |
|  | 100% <sup>2</sup> , NO deductible | 50%, NO deductible          |
| <b>ROUTINE GYNECOLOGICAL EXAM/PAP</b><br>1 per calendar year for women of any age <sup>3</sup> |                                   |                             |
|  | \$20 Copayment, NO deductible     | 50%, NO deductible          |
| <b>MAMMOGRAM</b>   |                                   |                             |
|  | 100%, NO deductible               | 50%, 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



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](http://www.ibx.com)

| Benefit  | In-Network                                      | Out-of-Network <sup>1</sup>                     |
|--|---|---|
| <b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b><br>6 visits per calendar year <sup>3</sup> | 100%, NO deductible                             | 50%, after deductible                           |
| <b>OUTPATIENT LABORATORY/PATHOLOGY</b>   | 70%, after deductible                           | 50%, after deductible                           |
| <b>MATERNITY</b>   |   |   |
| First OB visit   | \$20 Copayment, NO deductible                   | 50%, after deductible                           |
| Hospital   | 70%, after deductible                           | 50%, after deductible                           |
| <b>INPATIENT HOSPITAL SERVICES</b>   | 70%, after deductible                           | 50%, after deductible                           |
| <b>INPATIENT HOSPITAL DAYS</b>   | Unlimited                                       | 70  |
| <b>OUTPATIENT SURGERY</b>  | 70%, after deductible                           | 50%, after deductible                           |
| <b>EMERGENCY ROOM</b>  | 70%, after deductible; (not waived if admitted) | 70%, after deductible; (not waived if admitted) |
| <b>AMBULANCE</b>   | 70%, after deductible                           | 50%, after deductible                           |
| <b>OUTPATIENT X-RAY/RADIOLOGY</b>  |   |   |
| Routine Radiology/Diagnostic   | 70%, after deductible                           | 50%, after deductible                           |
| MRI/MRA, CT/CTA Scan, PET Scan   | 70%, after deductible                           | 50%, after deductible                           |
| <b>THERAPY SERVICES</b>  |   |   |
| Physical and Occupational<br>30 visits per calendar year <sup>3</sup>                        | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| Cardiac Rehabilitation<br>36 visits per calendar year <sup>3</sup>                           | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| Pulmonary Rehabilitation<br>36 visits per calendar year <sup>3</sup>                         | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| Speech<br>20 visits per calendar year <sup>3</sup>   | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| Orthoptic/Pleoptic<br>8 session lifetime maximum <sup>3</sup>                                | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| <b>SPINAL MANIPULATIONS</b><br>20 visits per calendar year <sup>3</sup>                      | \$40 Copayment, NO deductible                   | 50%, after deductible                           |
| <b>INJECTABLE MEDICATIONS</b>  |   |   |
| Standard Injectables   | 100%, NO deductible                             | 50%, after deductible                           |
| Biotech/Specialty Injectables  | \$100 Copayment, NO deductible                  | 50%, after deductible                           |
| <b>CHEMO/RADIATION/DIALYSIS</b>  | 70%, after deductible                           | 50%, after deductible                           |
| <b>OUTPATIENT PRIVATE DUTY NURSING</b><br>360 hours per calendar year <sup>3</sup>           | 70%, after deductible                           | 50%, after deductible                           |
| <b>SKILLED NURSING FACILITY</b><br>120 days per calendar year <sup>3</sup>                   | 70%, after deductible                           | 50%, after deductible                           |
| <b>HOSPICE AND HOME HEALTH CARE</b>  | 70%, after deductible                           | 50%, after deductible                           |

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3 Combined in/out-of-network

| Benefit   | In-Network                    | Out-of-Network <sup>1</sup>   |
|---|-------------------------------|---|
| <b>DURABLE MEDICAL EQUIPMENT</b>  | 50%, after deductible         | 50%, after deductible;<br>\$2,500 benefit maximum per calendar year |
| <b>PROSTHETICS</b>  | 50%, after deductible         | 50%, after deductible   |
| <b>MENTAL HEALTH CARE</b>   |                               |   |
| Outpatient<br>20 visits per calendar year <sup>3</sup>  | \$40 Copayment, NO deductible | 50%, after deductible   |
| Inpatient<br>30 days per calendar year <sup>3</sup>   | 70%, after deductible         | 50%, after deductible up to 20 days per calendar year               |
| <b>SERIOUS MENTAL ILLNESS CARE</b>  |                               |   |
| Outpatient<br>60 visits per calendar year <sup>3</sup>  | \$40 Copayment, NO deductible | 50%, after deductible   |
| Inpatient<br>30 days per calendar year <sup>3</sup>   | 70%, after deductible         | 50%, after deductible   |
| <b>SUBSTANCE ABUSE TREATMENT</b>  |                               |   |
| Outpatient/Partial Facility Visits<br>60 visits per calendar year <sup>3</sup> , 120 visits lifetime maximum <sup>3</sup> | \$40 Copayment, NO deductible | 50%, after deductible   |
| Rehabilitation<br>30 days per calendar year <sup>3</sup> , 90 day lifetime maximum <sup>3</sup>                           | 70%, after deductible         | 50%, after deductible   |
| Detoxification<br>7 days per admission <sup>3</sup> , 4 admissions lifetime maximum <sup>3</sup>                          | 70%, after deductible         | 50%, after deductible   |

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<sup>3</sup> Combined in/out-of-network

## 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
- Contraceptives
- Immunizations for travel or employment
- Services 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)

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 benefit booklet 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  
Maternity Admission (for notification only)

### OUTPATIENT FACILITY/OFFICE SERVICES (other than inpatient)

MRI/MRA  
CT/CTA Scan  
PET Scan  
Nuclear Cardiac Studies  
Hysterectomy  
Cataract Surgery  
Nasal Surgery for Submucous Resection and Septoplasty  
Transplants (except cornea)  
Comprehensive Outpatient Pain Management Programs (including epidural injections)  
Obesity Surgery  
Sleep Studies  
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)

#### BIRTHING CENTER (for notification 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

Abdominoplasty  
Augmentation Mammoplasty  
Blepharoplasty  
Chemical Peels  
Dermabrasion  
Excision of Redundant Skin  
Keloid Removal  
Lipectomy/Liposuction  
Orthognathic Surgery Procedures  
Mastopexy  
Otoplasty  
Panniculectomy  
Reduction Mammoplasty  
Removal or Reinsertion of Breast Implants  
Rhinoplasty  
Surgery for Varicose Veins  
Scar Revision  
Subcutaneous Mastectomy for Gynecomastia

### MENTAL HEALTH/SERIOUS MENTAL ILLNESS/SUBSTANCE ABUSE

Mental Health and Serious Mental Illness Treatment  
(Inpatient/Outpatient/Partial Hospitalization)  
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.