

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

C2-F4-01 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 a referral

Benefit	In-network	Out-of-network ¹
DEDUCTIBLE		
Individual	\$0	\$500
Family	\$0	\$1,500
OUT-OF-POCKET MAXIMUM		
Individual	None	\$3,000
Family	None	\$9,000
LIFETIME MAXIMUM		
	Unlimited	\$1 Million
DOCTOR'S OFFICE VISITS		
Primary care services	\$15 copayment	70%, after deductible
Specialist services	\$30 copayment	70%, after deductible
PEDIATRIC IMMUNIZATIONS		
	100% ²	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per calendar year for women of any age ³		
	\$15 copayment	70%, no deductible
MAMMOGRAM		
	100%	70%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT 6 visits per calendar year ³		
	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY		
	100%	70%, after 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.

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Benefit	In-network	Out-of-network ¹
MATERNITY		
First OB visit	\$15 copayment	70%, after deductible
Hospital	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible
INPATIENT HOSPITAL SERVICES		
	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible
INPATIENT HOSPITAL DAYS		
	Unlimited	70
OUTPATIENT SURGERY		
	\$125 copayment	70%, after deductible
EMERGENCY ROOM		
	\$100 copayment (copayment not waived if admitted)	\$100 copayment (copayment not waived if admitted)
AMBULANCE		
	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY (Copayment not applicable when service performed in ER or office setting)		
Routine Radiology/Diagnostic	\$30 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	\$60 copayment	70%, after deductible
THERAPY SERVICES		
Physical and occupational 30 visits per calendar year ³	\$30 copayment	70%, after deductible
Cardiac rehabilitation 36 visits per calendar year ³	\$30 copayment	70%, after deductible
Pulmonary rehabilitation 36 visits per calendar year ³	\$30 copayment	70%, after deductible
Speech 20 visits per calendar year ³	\$30 copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum ³	\$30 copayment	70%, after deductible
SPINAL MANIPULATIONS 20 visits per calendar year ³		
	\$30 copayment	70%, after deductible
INJECTABLE MEDICATIONS		
Standard Injectables	100%	70%, after deductible
Biotech/Specialty Injectables	\$75 copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS		
	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per calendar year ³		
	85%	70%, after deductible
SKILLED NURSING FACILITY 120 days per calendar year ³		
	\$125/day; maximum of 5 copayments/admission ⁴	70%, after deductible
HOSPICE AND HOME HEALTH CARE		
	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT		
	50%	50%, after deductible, \$2,500 benefit maximum per calendar year

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³ Combined in/out-of-network

⁴ Copayment waived if readmitted within 90 days of discharge

Benefit	In-network	Out-of-network ¹
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient 20 visits per calendar year ³	\$30 copayment	50%, after deductible
Inpatient 30 days per calendar year ³	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible, up to 20 days per calendar year
SERIOUS MENTAL ILLNESS CARE		
Outpatient 60 visits per calendar year ³	\$30 copayment	50%, after deductible
Inpatient 30 days per calendar year ³	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits 60 visits per calendar year ³ , 120 visits lifetime maximum ³	\$30 copayment	70%, after deductible
Rehabilitation 30 days per calendar year ³ , 90 day lifetime maximum ³	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible
Detoxification 7 days per admission ³ , 4 admissions lifetime maximum ³	\$250/day; maximum of 5 copayments/admission ⁴	70%, after deductible

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3 Combined in/out-of-network

4 Copayment waived if readmitted within 90 days of discharge

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
- self-injectable drugs (effective 1/1/2010)
- 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).

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 AND 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/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 you use 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.