Personal Choice

PC C2-F3-O1

Archdiocese of Phila

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	$1,000
Family	$0	$2,000
OUT-OF-POCKET MAXIMUM**		
Individual	$3,000	$6,000
Family	$6,000	$12,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$15 copayment	70%, after deductible
Specialist services	$40 copayment	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, no deductible	70%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply), no deductible	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP 1 per year for women of any age[2]	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.

2 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.

** In-network out-of-pocket maximum includes copayments, coinsurance and deductible. 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

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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 year[2]	100%, no deductible	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
MATERNITY		
First OB visit	$15 copayment	70%, after deductible
Hospital	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]
INPATIENT HOSPITAL SERVICES		
Facility	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[4]
OUTPATIENT SURGERY		
Facility	$100 copayment	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$150 copayment (copayment not waived if admitted)	$150 copayment, no deductible (copayment not waived if admitted)
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	$50 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	$100 copayment	70%, after deductible
THERAPY SERVICES		
Physical and occupational 30 visits per year for PT/OT combined[2]	$40 copayment	70%, after deductible
Cardiac rehabilitation 36 visits per year[2]	$40 copayment	70%, after deductible
Pulmonary rehabilitation 36 visits per year[2]	$40 copayment	70%, after deductible
Speech 20 visits per year[2]	$40 copayment	70%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum[2]	$40 copayment	70%, after deductible
SPINAL MANIPULATIONS 20 visits per year[2]	$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	$75 copayment	70%, after deductible

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2 Combined in/out-of-network

3 Copayment waived if readmitted within 10 days of discharge

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]
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING 360 hours per year[2]	85%	70%, after deductible
SKILLED NURSING FACILITY 120 days per year[2]	$75/day; maximum of 5 copayments/admission[3]	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT	50%	50%, after deductible
PROSTHETICS	50%	50%, after deductible
MENTAL HEALTH CARE		
Outpatient	$40 copayment	70%, after deductible
Inpatient	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$40 copayment	70%, after deductible
Inpatient	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$40 copayment	70%, after deductible
Rehabilitation	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]
Detoxification	$150/day; maximum of 5 copayments/admission[3]	70%, after deductible[4]

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What is not covered?

- reversal of voluntary sterilization
- 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
- Contraceptives
- Abortions, voluntary sterilizations and reversal of voluntary sterilizations
- 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

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 AND POTENTIALLY COSMETIC PROCEDURES

- Blepharoplasty/ptsosis 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 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.

Select Drug Program

$15/$35/$60

Independence

Arch/Parishes & Agencies

The Select Drug Program is a comprehensive benefit that provides coverage for prescription drugs[1] when prescribed by a licensed, practicing physician. The Select Drug Program® is based on an incentive formulary that includes all generic drugs and a defined list of brand drugs that have been evaluated for their medical effectiveness, positive results, and value. Generic drugs are just as effective as brand drugs and result in the lowest cost sharing for you. Ask your physician whether generic drugs are right for you.

Benefit	Coverage
Retail Pharmacy - Member Cost Sharing (Participating Pharmacy)	
Generic Formulary	$15 Copayment
Brand Formulary	$35 Copayment
Non-Formulary Brand	$60 Copayment
Mail Order Pharmacy - Member Cost Sharing (Participating Pharmacy) Available for maintenance drugs	
Generic Formulary	$15 Copayment (1-30 days supply); $37.50 Copayment (31-90 days supply)
Brand Formulary	$35 Copayment (1-30 days supply); $87.50 Copayment (31-90 days supply)
Non-Formulary Brand	$60 Copayment (1-30 days supply); $150 Copayment (31-90 days supply)
Out-of-Network Reimbursement	30% of drugs retail cost for the total amount dispensed. Member must submit for reimbursement.
Network	FutureScripts® network* includes more than 60,000 retail pharmacies. You can locate a participating pharmacy near you on **www.ibx.com** by selecting the *Find a Participating Pharmacy* feature.
Dispensing Limits	
Retail	Up to 30 days supply
Mail order for maintenance drugs	Up to 90 days supply
Formulary	IBC Select Drug Program Formulary. To check the formulary status of a drug or to view a copy of the most recent formulary, log onto **www.ibx.com**.
Covered Prescription Drugs[1]	Compound medications of which at least one ingredient is a prescription drug Self-injectable drugs

1 This summary is intended to highlight the benefits available to you. For a complete program description, including all benefits, limitations, and exclusions, refer to your benefit booklet or group contract.

* FutureScripts is an independent company providing pharmacy benefit management services.

Benefit	Coverage
Covered Prescription Drugs[1] (Continued)	Prescribed Smoking Cessation Drugs Retin-A through age 35 Insulin Insulin needles and syringes Lancets (no copayment required at participating pharmacies) Glucometers (no copayment required at participating pharmacies) Diabetic supplies (i.e., test strips)

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What is Not Covered?

- Injectable fertility drugs
- Non Federal Legend Drugs
- Weight control drugs
- Devices or supplies except those specifically listed under covered drugs
- Drugs used for cosmetic purposes (e.g., anabolic steroids and minoxidil lotion, Retin-A for aging skin)
- Drugs labeled 'Caution-limited by Federal Law to investigational use', even though a charge is made to an individual
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order
- Experimental drugs
- Contraceptives (e.g. Orals, Devices, Injections, IUD's)
- Immunization agents, biologicals, allergy serums, blood, or blood plasma
- Drugs and supplies that can be purchased over the counter except those covered per mandate (with a doctor's prescription)