Personal Choice

PHO

Univ of Penn - PennCare

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 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

Benefits	In-Network PENNCare Network	Personal Choice Network	Out-of-Network Out-of-Network***
BENEFIT PERIOD	Contract Year*	Contract Year*	Contract Year*
DEDUCTIBLE accumulates across PENNCare and Personal Choice networks			
Individual	$150	$350	$500
Family	$450	$1,050	$1,500
COINSURANCE	90%, after deductible	80%, after deductible	60%, after deductible
OUT-OF-POCKET MAXIMUM *(includes deductible, coinsurance, and copay amounts accumulated across PENNCare and Personal Choice networks)*			
Individual	$1,000	$2,500	$3,500
Family	$3,000	$7,200	$10,500
LIFETIME MAXIMUM	None	None	None
DOCTOR'S OFFICE VISITS			
Primary Care Services	$20 Copayment	$25 Copayment	60%, after deductible
Specialist Services	$30 Copayment	$40 Copayment	60%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%, NO deductible	100%, NO deductible	60%, NO deductible
PEDIATRIC IMMUNIZATIONS	100%, NO deductible	100%, NO deductible	60%, NO deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per contract year for women of any age*	100%, NO deductible	100%, NO deductible	60%, NO deductible
MAMMOGRAM	100%, NO deductible	100%, NO deductible	60%, NO deductible
EMERGENCY ROOM	$100 copayment, NO deductible (waived if admitted)	$100 Copayment, NO deductible (waived if admitted)	$100 Copayment, NO deductible (waived if admitted)
URGENT CARE FACILITY	Not available	$50 Copayment	60%, after deductible
RETAIL CLINIC	Not available	$30 Copayment	60%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%, NO deductible	100%, NO deductible	60%, after deductible

* Your group's benefit period is based on a contract year. The contract year is a consecutive 12-month period that begins on your employer's effective date which is July 1, 2016.

*** Out-of-network, non-participating 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. 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.

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

Independence

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Benefits	In-Network PENNCare Network	Personal Choice Network	Out-of-Network Out-of-Network***
OUTPATIENT X-RAY/RADIOLOGY			
Routine Radiology/Diagnostic	90%, after deductible	80%, after deductible	60%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	90%, after deductible	80%, after deductible	60%, after deductible
ASSISTED REPRODUCTIVE TECHNOLOGIES (only at HUP) *Invitro Fertilization limited to 2 cycles per lifetime*	$30 Copayment for initial visit only, then 90% after deductible	Not Covered	Not Covered
MATERNITY			
First OB visit	$30 Copayment for initial visit	$40 Copayment for initial visit	60%, after deductible
Obstetrical/Maternity Care****	90%, after deductible	80%, after deductible	60%, after deductible
Hospital	90%, after deductible (including emergency admissions)	80% after deductible (including emergency admissions)	60%, after deductible[1]
ELECTIVE ABORTION	90%, after deductible	80%, after deductible	60%, after deductible
INPATIENT HOSPITAL SERVICES			
Facility	Covered 90%, after deductible (including emergency admissions)	Covered 80%, after deductible (including emergency admissions)	60%, after deductible[1]
Physician/Surgeon	Covered 90%, after deductible	Covered 80%, after deductible	60%, after deductible
INPATIENT HOSPITAL DAYS	365	365	70[1]
INPATIENT CONSULTATIONS	90%, after deductible	80%, after deductible	60%, after deductible
OUTPATIENT HOSPITAL SERVICES	90%, after deductible	80%, after deductible	60%, after deductible
OUTPATIENT SURGERY**			
Facility	90%, after deductible	80%, after deductible	60%, after deductible
Physician/Surgeon	90%, after deductible	80%, after deductible	60%, after deductible
ASSISTANT SURGEON	90%, after deductible	80%, after deductible	60%, after deductible
ANESTHESIA	90%, after deductible	80%, after deductible	60%, after deductible
SECOND SURGICAL OPINION (Voluntary)	90%, after deductible	80%, after deductible	60%, after deductible
AMBULANCE			
Emergency	100%, NO deductible	100%, NO deductible	100%, NO deductible
Non-Emergency	90%, after deductible	80%, after deductible	60%, after deductible
THERAPY SERVICES			
Physical, Speech and Occupational 60 visits per contract year**	$30 Copayment	$40 Copayment	60%, after deductible
Cardiac Rehabilitation 36 visits per contract year**	$30 Copayment	$40 Copayment	60%, after deductible
Pulmonary Rehabilitation 36 visits per contract year**	$30 Copayment	$40 Copayment	60%, after deductible
Orthoptic/Pleoptic 8 sessions lifetime maximum**	Not available	$40 copayment	60%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE *60 visits per contract year***	Not available	$40 Copayment	60%, after deductible
INJECTABLE MEDICATIONS			
Standard Injectables	100%, NO deductible[2]	100%, NO deductible[2]	60%, after deductible
Biotech/Specialty Injectables	$50 copayment	$50 copayment	60%, after deductible
CHEMO / RADIATION / DIALYSIS	90%, after deductible	80%, after deductible	60%, after deductible
OUTPATIENT PRIVATE DUTY NURSING	90%, after deductible	80%, after deductible	60%, after deductible
SKILLED NURSING FACILITY *180 days per contract year*	90%, after deductible	80%, after deductible	60%, after deductible
HOSPICE	90%, after deductible	80%, after deductible	60%, after deductible
HOME HEALTH CARE	90%, after deductible	80%, after deductible	60%, after deductible
INFUSION THERAPY	90%, after deductible	80%, after deductible	60%, after deductible
DURABLE MEDICAL EQUIPMENT***	Not available	80%, after deductible	60%, after deductible

** Visit, day and hour maximums are a combination of in-network and out-of-network services.

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**** Tubal ligation is covered at 100%, no deductible under PENNCare Network and Personal Choice Network.

***** Breast pump rentals are covered at 100%, no deductible under PENNCare Network and Personal Choice Network.

1 Inpatient hospital day limit combined for all out-of-network inpatient medical and maternity services

2 Office visit subject to copayment

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Benefits	In-Network PENNCare Network	Personal Choice Network	Out-of-Network Out-of-Network***
PROSTHETICS *inlcudes coverage for wigs*	Not available	80%, after deductible	60%, after deductible
CONTRACEPTIVE DEVICES	100%, NO deductible	100%, NO deductible	60%, after deductible
OUTPATIENT DIABETIC EDUCATION	100%, NO deductible	100%, NO deductible	Not Covered
MEDICAL FOODS AND NUTRITION FORMULAS	Not available	80%, after deductible	60%, after deductible
BLOOD	90%, after deductible	80%, after deductible	60%, after deductible
DIABETIC EQUIPMENT AND SUPPLIES	Not available	80%, after deductible	60%, after deductible

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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
- 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
- Routine physical exams for non-preventive 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
- Vision care (except as specified in a group contract)
- Mental health substance abuse treatment services
- Self-injectable

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 (275-2583). For questions related to Mental Health/Substance Abuse services, call PENN BEHAVIORAL HEALTH at 1-888-321-5533.

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.