

# Personal Choice

C2-F1-01



## DELCO TRUST

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 <sup>1</sup>
<b>BENEFIT PERIOD</b>	Contract Year <sup>2</sup>	Contract Year <sup>2</sup>
<b>DEDUCTIBLE</b>		
Individual	\$0	\$500
Family	\$0	\$1,500
<b>OUT-OF-POCKET MAXIMUM<sup>5</sup></b>		
Individual	\$1,000	\$3,000
Family	\$2,000	\$9,000
<b>LIFETIME MAXIMUM</b>	Unlimited	Unlimited
<b>DOCTOR'S OFFICE VISITS</b>		
Primary care services	\$15 copayment	70%, after deductible
Specialist services	\$30 copayment	70%, after deductible
<b>PREVENTIVE CARE FOR ADULTS AND CHILDREN</b>	100%	70%, no deductible
<b>PEDIATRIC IMMUNIZATIONS</b>	100% (office visit copayment does not apply)	70%, no deductible
<b>ROUTINE GYNECOLOGICAL EXAM/PAP</b> <i>1 per year for women of any age<sup>3</sup></i>	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 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.

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.



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>MAMMOGRAM</b>	100%	70%, no deductible
<b>NUTRITION COUNSELING FOR WEIGHT MANAGEMENT</b> <i>6 visits per year<sup>3</sup></i>	100%	70%, after deductible
<b>OUTPATIENT LABORATORY/PATHOLOGY</b>	100%	70%, after deductible
<b>MATERNITY</b>		
First OB visit	\$15 copayment	70%, after deductible
Hospital	100%	70%, after deductible <sup>4</sup>
<b>INPATIENT HOSPITAL SERVICES</b>		
Facility	100%	70%, after deductible <sup>4</sup>
Physician/Surgeon	100%	70%, after deductible
<b>INPATIENT HOSPITAL DAYS</b>	Unlimited	70 <sup>4</sup>
<b>OUTPATIENT SURGERY</b>		
Facility	100%	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
<b>EMERGENCY ROOM</b>	\$100 copayment (copayment not waived if admitted)	\$100 copayment (copayment not waived if admitted); no deductible
<b>URGENT CARE CENTER</b>	\$70 copayment	70%, after deductible
<b>AMBULANCE</b>		
Emergency	100%	100%, no deductible
Non-emergency	100%	70%, after deductible
<b>OUTPATIENT X-RAY/RADIOLOGY</b> <i>(Copayment not applicable when service performed in ER or office setting)</i>		
Routine Radiology/Diagnostic	\$30 copayment	70%, after deductible
MRI/MRA, CT/CTA Scan, PET Scan	\$60 copayment	70%, after deductible
<b>THERAPY SERVICES</b>		
Physical and occupational 30 total visits per year for PT/OT combined <sup>3</sup>	\$30 copayment	70%, after deductible
Cardiac rehabilitation 36 visits per year	\$30 copayment	70%, after deductible
Pulmonary rehabilitation 36 visits per year <sup>2</sup>	\$30 copayment	70%, after deductible
Speech 20 visits per year <sup>3</sup>	\$30 copayment	70%, after deductible
Orthoptic/Pleoptic 8 session lifetime maximum <sup>3</sup>	\$30 copayment	70%, after deductible
<b>SPINAL MANIPULATIONS</b> <i>20 visits per year<sup>2</sup></i>	\$30 copayment	70%, after deductible
<b>ALLERGY INJECTIONS</b> <i>(Office visit copayment waived if no office visit is charged)</i>	100%	70%, after deductible
<b>INJECTABLE MEDICATIONS</b>		
Standard Injectables	100% <sup>2</sup>	70%, after deductible
Biotech/Specialty Injectables	\$75 copayment	70%, after deductible

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2 Office visit subject to copayment

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 <sup>1</sup>
<b>CHEMO/RADIATION/DIALYSIS</b>	100%	70%, after deductible
<b>OUTPATIENT PRIVATE DUTY NURSING</b> <i>360 hours per year<sup>3</sup></i>	90%	70%, after deductible
<b>SKILLED NURSING FACILITY</b> <i>120 days per year<sup>3</sup></i>	100%	70%, after deductible
<b>HOSPICE AND HOME HEALTH CARE</b>	100%	70%, after deductible
<b>DURABLE MEDICAL EQUIPMENT</b>	70%	50%, after deductible
<b>PROSTHETICS</b>	70%	50%, after deductible
<b>MENTAL HEALTH CARE</b>		
Outpatient	\$30 copayment	70%, after deductible
Inpatient	100%	70%, after deductible <sup>4</sup>
<b>SERIOUS MENTAL ILLNESS CARE</b>		
Outpatient	\$30 copayment	70%, after deductible
Inpatient	100%	70%, after deductible <sup>4</sup>
<b>SUBSTANCE ABUSE TREATMENT</b>		
Outpatient/Partial facility visits	\$30 copayment	70%, after deductible
Rehabilitation	100%	70%, after deductible <sup>4</sup>
Detoxification	100%	70%, after deductible <sup>4</sup>

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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
- 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.