Personal Choice

PC 20/30/70

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 Blue Card® 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	Contract Year*	Contract Year*
DEDUCTIBLE		
Individual	$0	$500
Family	$0	$1,000
AFTER DEDUCTIBLE, PLAN PAYS	100%	70%
OUT-OF-POCKET MAXIMUM[6]		
Individual	$1,500	$3,000
Family	$3,000	$6,000
LIFETIME MAXIMUM	Unlimited	Unlimited
DOCTOR'S OFFICE VISITS		
Primary care services	$20 copayment	70%, after deductible
Specialist services	$30 copayment	70%, after deductible
PREVENTIVE CARE FOR ADULTS AND CHILDREN	100%	70%, no deductible
PEDIATRIC IMMUNIZATIONS	100% (office visit copayment does not apply)	70%, no deductible
ROUTINE GYNECOLOGICAL EXAM/PAP *1 per year for women of any age*[3]	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.

6 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.

Independence

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Benefit	In-network	Out-of-network[1]
MAMMOGRAM	100%	70%, no deductible
NUTRITION COUNSELING FOR WEIGHT MANAGEMENT *6 visits per year*[3]	100%	70%, after deductible
ALLERGY INJECTIONS *(Office visit copayment waived if no office visit is charged)*	100%	70%, after deductible
MATERNITY		
First OB visit	$20 copayment	70%, after deductible
Hospital	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]
INPATIENT HOSPITAL SERVICES		
Facility	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]
Physician/Surgeon	100%	70%, after deductible
INPATIENT HOSPITAL DAYS	Unlimited	70[5]
OUTPATIENT SURGERY		
Facility	$150 copayment	70%, after deductible
Physician/Surgeon	100%	70%, after deductible
EMERGENCY ROOM	$40 copayment (copayment waived if admitted)	$40 copayment, no deductible (copayment waived if admitted)
URGENT CARE CENTER	$28 copayment	70%, after deductible
AMBULANCE		
Emergency	100%	100%, no deductible
Non-emergency	100%	70%, after deductible
OUTPATIENT LABORATORY/PATHOLOGY	100%	70%, after deductible
OUTPATIENT X-RAY/RADIOLOGY *Copayment not applicable when service performed in ER or office setting*	$30 copayment	70%, after deductible
THERAPY SERVICES		
Physical, speech and occupational 60 visits per year for PT/ST/OT combined[3]	$20 copayment [visits 1-30] $30 copayment [visits 31-60]	70%, after deductible
Cardiac rehabilitation 36 visits per year[3]	$20 copayment	70%, after deductible
Pulmonary rehabilitation 12 visits per year[3]	$20 copayment	70%, after deductible
RESTORATIVE SERVICES, INCLUDING CHIROPRACTIC CARE (30 visits per year)[3] Orthoptic/pleoptic therapy limited to 8 sessions lifetime maximum[3]	$30 copayment	70%, after deductible
CHEMO/RADIATION/DIALYSIS	100%	70%, after deductible
OUTPATIENT PRIVATE DUTY NURSING *360 hours per year*[3]	100%	70%, after deductible
SKILLED NURSING FACILITY *120 days per year*[3]	100%	70%, after deductible
HOSPICE AND HOME HEALTH CARE	100%	70%, after deductible
DURABLE MEDICAL EQUIPMENT AND PROSTHETICS *Copayment per rental period or item purchased*	$30 copayment	70%, after deductible

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3 Combined in/out-of-network

4 Copayment waived if readmitted within 10 days of discharge

5 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]
OUTPATIENT DIABETIC EDUCATION	100%	Not covered
MENTAL HEALTH CARE		
Outpatient	$30 copayment	70%, after deductible
Inpatient	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]
SERIOUS MENTAL ILLNESS CARE		
Outpatient	$30 copayment	70%, after deductible
Inpatient	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]
SUBSTANCE ABUSE TREATMENT		
Outpatient/Partial facility visits	$30 copayment	70%, after deductible
Rehabilitation	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]
Detoxification	$150 per day (maximum of 5 copayments per admission)[4]	70%, after deductible[5]

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What is not covered?

- services not medically necessary
- services not billed and performed by a provider properly licensed and qualified to render the medically necessary treatment, service, or supply
- cosmetic services/supplies
- routine foot care
- supportive devices for the foot (orthotics), except for podiatric appliances for the prevention of complications associated with diabetes
- dental care, including dental implants, and nonsurgical treatment of temporomandibular joint syndrome (TMJ)
- vision care (except as specified in a group contract)
- military or occupational injuries or illness
- benefits payable by the government, Medicare, or through motor vehicle insurance
- assisted fertilization techniques such as, but not limited to, in-vitro fertilization, artificial insemination, GIFT, ZIFT
- charges in excess of benefit maximums or allowable charges as set forth in the group contract
- services or supplies that are experimental or investigative except routine costs associated with clinical trials
- inpatient private-duty nursing
- alternative therapies/complementary medicine
- hearing aids, hearing examinations/tests for the prescription/fitting of hearing aids, and cochlear electromagnetic hearing devices
- immunizations required for employment or travel

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.